**Initial Action by Children’s Social Care on Receipt of a Referral**

All referrals to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should initially be regarded as children in potential need, and the referral should be evaluated on the day of receipt (and no later than within one working day), and a decision made and recorded (by the locally defined appropriate level of social worker / manager) regarding the next course of action.

All contacts by public and professionals expressing any concerns about the welfare of a child must be treated as a referral and recorded as such (i.e. not screened out on a contact record e.g. of the Integrated Children’s System).

Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) must acknowledge referrals within one working day of receipt.

When taking a referral, staff must establish as much of the following information as possible:

* Cause for concern including details of any allegations, their sources, timing and location;
* Child’s current location and emotional and physical condition;
* Whether the child needs immediate protection;
* Full names, date of birth and gender of child(ren);
* Family address (current and previous);
* Identity of those with Parental Responsibility;
* Names and date of birth of all household members and any known regular visitors to the household;
* Details of child’s extended family or community who are significant for the child;
* Ethnicity, first language and religion of children and parents / carers;
* Any need for an interpreter, signer or other communication aid;
* Any special needs of child(ren) and other household members;
* Any significant / important recent or historical events / incidents in child or family’s life, including previous concerns;
* Details of any alleged perpetrators (if relevant);
* Background information relevant to referral e.g. positive aspects of parents care, previous concerns, pertinent parental issues (such as mental health, domestic violence, drug or alcohol [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), threats and violence towards professionals);
* Referrer’s relationship and knowledge of child and parents / carers;
* Known current or previous involvement of other agencies / professionals e.g. schools, GPs;
* Information regarding parental knowledge of, and agreement to, the referral.

Referrers should be asked specifically if they hold any information about difficulties being experienced by the family/household due to [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/), mental illness, substance misuse, and/or learning difficulties Referrer’s relationship and knowledge of child and parents / carers.

**Screening of Referrals by Children’s Social Care**

The screening process should establish:

* The nature of the concern;
* How and why it has arisen;
* What the child’s needs appear to be;
* Whether the concern involves [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect; and
* Whether there is any need for any urgent action to protect the child or any other children in the household or children in any other household.

This above process will involve:

* Discussion with referrers;
* Consideration of any existing records for the child and for any other members of the household;
* Involving other agencies as appropriate (including the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) if any offence has been or is suspected to have been committed).

Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) will also take account of the thresholds of need and intervention set out in the [Effective Support for Children and Families in Cambridgeshire and Peterborough (Thresholds) Document](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/11/Effective-Support-for-Children-and-Families-Thresholds-Document.pdf).

Personal information about non-professional referrers should not be disclosed to third parties (including subject families and other agencies) without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/).

Parents’ [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) should be sought before discussing a referral about them with other agencies unless this may:

* Place the child at risk of Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) g. by the behavioural response it prompts or by leading to an unreasonable delay;
* Lead to the risk of loss of evidential material.

[See also Information Sharing and Confidentiality.](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/information-sharing/)

The line manager should authorise any decision to discuss the referral with other agencies without parental knowledge or permission and the reasons for such action recorded.

This screening stage must involve immediate evaluation of any concerns about either the child’s health and development, or actual and/or potential [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), which justify further enquiries, assessments and/or interventions.

The line manager should be informed of any potential Section 47 Enquiries and authorise the decision to initiate a Strategy Discussion. If the child and/or family are well known to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and/or the facts clearly indicate that Section 47 Enquiries are required, it may be appropriate to hold a Strategy Discussion without further assessment.

The threshold may be met for a Section 47 Enquiry at the time of referral, during Child and Family Assessment or at any point of Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)involvement.

**Where a Crime may have been Committed**

The [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) must be informed at the earliest opportunity if a crime may have been committed. The [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) must decide whether to commence a criminal investigation and a discussion held to plan how parents are to be informed of concerns without jeopardising [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) investigations (see Section 47 Enquiries Procedure, Liaison between Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) – Single or Joint Agency Enquiries/Investigations).

**Outcome of Referrals**

The immediate response to a referral may be:

* No further action, provision of information and advice or signposting to another agency
* Referral for services under Early Help
* A Child and Family Assessment
* A Strategy Discussion/Meeting (where child and / or family are well known or the facts clearly indicate that this is required)
* Emergency action to protect a child – see Immediate Protective Action

A manager must sign and approve the outcomes of the referral and ensure a chronology has been commenced and / or updated.

Where there are concerns identified about any adults at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), a referral should be made to Adult [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) under the Cambridgeshire and Peterborough [Safeguarding Adults](https://www.safeguardingcambspeterborough.org.uk/glossary/safeguarding-adults/) Board Procedures.

Where there is to be no further action, feedback should be provided to family and referrers about the outcome of this stage of the referral.

In the case of referrals from members of the public, feedback must be consistent with the rights to confidentiality of child and her/his family.

Where a referrer is dissatisfied with the outcome of the referral, consideration to further action identified in Resolving Professional Disagreements (Escalation) Procedure should be considered.

Diagram

Description automatically generated

**Breast Ironing**

**1. Introduction**

Breast Ironing also known as ‘Breast Flattening’ is the process whereby young pubescent girls breasts are ironed, massaged and/or pounded down through the use of hard or heated objects in order for the breasts to disappear or delay the development of the breasts entirely. It is believed that by carrying out this act, young girls will be protected from harassment, rape, abduction and early forced marriage and therefore be kept in education.

Much like Female Genital Mutilation (FGM), Breast Ironing is a harmful cultural practice and is child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Professionals working with children and young people must be able to identify the signs and symptoms of girls who are at risk of or have undergone breast ironing. Similarly to Female Genital Mutilation (FGM), breast ironing is classified as physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

**2. Definition**

The United Nations (UN) states that Breast Ironing affects 3.8 million women around the world and has been identified as one of the five under-reported crimes relating to gender-based violence. The custom uses large stones, a hammer or spatulas that have been heated over scorching coals to compress the breast tissue of girls as young as 9 years old. Those who derive from richer families may opt to use an elastic belt to press the breasts so as to prevent them from growing.

The mutilation is a traditional practice from Cameroon designed to make teenage girls look less ‘womanly’ and to deter unwanted male attention, pregnancy and rape. The practice is commonly performed by family members, 58% of the time by the mother. In many cases the abuser thinks they are doing something good for their daughter, by delaying the effects of puberty so that she can continue her education, rather than getting married.

**3. Law**

There is no specific law within the UK around Breast Ironing; however it is a form of [Physical Abuse](http://trixresources.proceduresonline.com/nat_key/keywords/physical_abuse.html)and if professionals are concerned a child may be at risk of or suffering [Significant Harm](http://trixresources.proceduresonline.com/nat_key/keywords/significant_harm.html) they must act in accordance with [Making a Referral to Children Social Care](http://www.peterboroughlscb.org.uk/children-board/professionals/procedures/making-referrals-to-childrens-social-care/). Local authorities should review their internal Violence against Women and Girls strategy and ensure it reflects breast ironing as a form of gender based violence.

The rights of women and girls are enshrined by various universal and regional instruments including:

* [The Universal Declaration of Human Rights](http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf);
* [The United Nations Convention on the Elimination of all Forms of Discrimination Against Women](http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf);
* [The United Nations Convention on the Rights of the Child](https://www.unicef.org.uk/what-we-do/un-convention-child-rights/);
* [The African Charter on Human and Peoples’ Rights](http://www.humanrights.se/wp-content/uploads/2012/01/African-Charter-on-Human-and-Peoples-Rights.pdf);
* [Protocol to the African Charter on Human and Peoples’ Rights on the rights of Women in Africa](http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf).

All these documents highlight the right for girls and women to live free from gender discrimination, free from torture, to live in dignity and with bodily integrity.

There have been no prosecutions related to breast ironing and there are no figures available for the number of teenage girls who might be affected within the UK. CAME Women’s and Girl’s Development Organisation (Cawogido) is working in Cameroon and the UK to tackle the issue of breast ironing and believe that, similarly to FGM, the practice is happening but due to the hidden nature of the act it is difficult to detect.

**4. Risks**

The girl generally believes that the practice is being carried out for her own good and she will often remain silent. Young pubescent girls usually aged between 9 – 15 years old and from practising communities are most at risk of breast ironing.

**5. Indicators**

Breast ironing is a well-kept secret between the young girl and her mother. Often the father remains completely unaware. Some indicators that a girl has undergone breast ironing are as follows:

* + Unusual behaviour after an absence from school or college including depression, anxiety, aggression, withdrawn etc;
  + Reluctance in undergoing normal medical examinations;
  + Some girls may ask for help, but may not be explicit about the problem due to embarrassment or fear;
  + Fear of changing for physical activities due to scars showing or bandages being visible.

**6. Issues**

**Where is it practiced?**

Breast ironing is practiced in all ten regions of Cameroon and has been reported in Benin, Ivory Coast, Chad, Guinea-Bissau, Kenya, Togo, Zimbabwe and Guinea-Conakry. The charity [CAWODIGO – CAME Women and Girls](http://www.cawogido.co.uk/index.php), is concerned that African immigrants have brought breast ironing practice with them to the UK. In their efforts to reduce the number of affected girls and women, CAME provides training for Cameroonian organisations working to protect girls from being abused through breast ironing and supporting families and communities.

**Health consequences**

Due to the instruments which are used during the process of breast ironing, for example, spoon/broom, stones, pestle, breast band, leaves etc. combined with insufficient aftercare, young girls are exposed to significant health risks. Breast ironing is painful and violates a young girl’s physical integrity. It exposes girls to numerous health problems such as cancer, abscesses, itching, and discharge of milk, infection, dissymmetry of the breasts, cysts, breast infections, severe fever, tissue damage and even the complete disappearance of one or both breasts.

This form of mutilation not only has negative health consequences for the girls, but often proves futile when it comes to deterring teenage sexual activity according to CAME Women and Girls. The practice not only seriously damages a child’s physical integrity, but also their social and psychological well-being.

**Justifications**

The practice is carried out under the misguided intention of ‘protecting’ women and girls from men’s sexual harassment. These violent acts are not only perpetrated by men on women, but by older generations of women on young girls. In practicing communities, it is believed many boys and men believe girls whose breasts have grown are ready to have sex, therefore elders (mothers, grandmothers, aunties etc.) believe that by suppressing a girl’s development of her breast she will be protected from rape, kidnapping, sexual harassment and early forced marriage.

**End**

**Bullying**

**Definition**

Bullying is defined as “behaviour by an individual or group, usually repeated over time, that intentionally hurts another individual or group either physically or emotionally” (DfE definition).

It can be inflicted on a child by another child or an adult.

It can take many forms, but the three main types are:

* Physical – for example, hitting, kicking, shoving, theft;
* Verbal – for example, threats, name calling, racist or homophobic remarks;
* Emotional – for example, isolating an individual from activities/games and the social acceptance of their peer group.

Cyber bullying / online bullying is defined as “the use of Information Communications Technology (ICT), particularly mobile phones and the internet, deliberately to upset someone else” (DfE definition).

Bullying often starts with apparently trivial events such as teasing and name calling which nevertheless rely on an [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of power. Such abuses of power, if left unchallenged, can lead to more serious forms of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), such as domestic violence, racial attacks, sexual offences and self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or suicide.

**2. The Child**

**2.1 The Child Victim**

The damage inflicted by bullying can often be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes depression and self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

Children are often held back from telling anyone about their experience either by threats or by a feeling that nothing can change their situation.

Parents, carers and agencies need to be alert to any changes in behaviour such as refusing to attend school or a particular place or activity, becoming anxious in public places and crowds and becoming withdrawn and isolated. Parents should be provided with information as what they should do if they are worried that their child is being bullied – i.e. where they can obtain advice and support including keeping safe on the internet.

Any child may be bullied, but bullying often occurs if a child has been identified in some ways as vulnerable, different or inclined to spend more time on his or her own. Bullying may be fuelled by prejudice – racial, religious, homophobic and against children with special education needs or disabilities or who are perceived as different in some way. 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 for this form of bullying to be characterised by inappropriate sexual behaviour and the risk of serious violence (including sexual violence).

Children living away from home are particularly vulnerable to bullying and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) by their peers.

**2.2 The Child Bully**

Children, who bully, have often been bullied themselves and suffered considerable disruption in their own lives. The bullying behaviour may occur because the child is unhappy, jealous or lacking in confidence.

Work with children who bully should recognise that they are likely to have significant needs themselves.

**3. Action and Prevention**

All settings in which children are provided with services or are living away from home should have in place anti-bullying strategies. This includes schools as well as all youth clubs and all other children’s organisations where the anti-bullying strategies should be rigorously enforced.

* A sense of community will be achieved only if organisations take seriously behaviour which upsets children;
* Promotion of all children within the setting counters isolation of individuals by others, nurtures friendships between children and, where it is a residential setting, supports them to adapt to their living arrangements;
* Support should be offered to children for whom English is not their first language to communicate needs and concerns;
* Children should be able to approach any member of staff within the organisation with personal concerns.

In order to maintain an effective strategy for dealing with bullying, the traditional ideas about bullying should be challenged, e.g.

* It’s only a bit of harmless fun;
* It’s all part of growing up;
* Children just have to put up with it;
* Adults getting involved make it worse.

Clear messages must be given that bullying is not acceptable and children must be reassured that significant adults involved in their lives are dealing with bullying seriously. Some acts of bullying could be a criminal offence.

A climate of openness should be established in which children are not afraid to address issues and incidents of bullying.

Consideration should always be given to the existence of any underlying issues in relation to race, gender and sexual orientation. This should be addressed and challenged accordingly.

Where a child is thought to be exposed to bullying, action should be taken to assess the child’s needs and provide support services.

A range of active listening techniques which provide a more helpful response include:

|  |  |
| --- | --- |
| **Technique** | **Suggested Response** |
| **THE LISTENER:** | Listening patiently with full attention, encouraging, clarifying, restating, reflecting, validating, summarising. |
| **THE DETECTIVE:** | Investigating the situation sensitively and patiently. |
| **THE SUPPORTER:** | Seeing their side, acknowledging and allowing expression of their feelings. |
| **THE COACH:** | Checking out what help is being asked for and offering practical, realistic help. |

Where appropriate, parents should be informed and updated on a regular basis. They should also, when applicable, be involved in supporting programmes devised to challenge bullying behaviour.If the bullying involves a physical assault, as well as seeking medical attention where necessary, consideration should be given to whether there are any child protection issues to consider and whether there should be a referral to the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) where a criminal offence may have been committed.

**4. Dealing with Incidents of Bullying by Children**

Creating an Anti-Bullying climate that is conducive to equality of opportunity, co-operation and mutual respect for differences can be achieved by, for example:

* Low Tolerance of Minor Bullying – “Nipping in the bud” the incidents at the earliest sign;
* Never ignoring victims of bullying, always showing an interest/concern;
* Publicly acknowledging the bullied child’s distress;
* Organising quality groups/circles, which allow children to work together to identify their own problems, the causes and the solutions, with sensitive facilitators.

It is important when addressing bullying behaviour by another child to avoid accusations, threats or any responses that will only lead to the child being uncooperative, and silent.

The focus should be on the bully behaviour rather than the child and where possible the reasons for the behaviour should be explored and dealt with. A clear explanation of the extent of the upset the bullying has caused should be given and encouragement to see the bullied child’s points of view.

The children (bully and bullied) should be carefully assessed and closely monitored. The times, places and circumstances in which the risk of bullying is greatest should be ascertained and action taken to reduce the risk of recurrence.

Whatever plan of action is implemented after the above issues have been identified, the plan must be reviewed with regular intervals and amended if necessary to ensure that the bullying has ceased.

**Child and family assessment**

**1. Focus on the Child**

Children should to be seen and listened to and included throughout the assessment process. Their ways of communicating should be understood in the context of their family and community as well as their behaviour and developmental stage. It is important that the impact of what is happening to a child is clearly identified and that information is gathered, recorded and checked systematically, and discussed with the child and their parents/carers where appropriate.

Assessments, service provision and decision making should regularly review the impact of the assessment process and the services provided on the child so that the best outcomes for the child can be achieved. Any services provided should be based on a clear analysis of the child’s needs, and the changes that are required to improve the outcomes for the child.

Children should be actively involved in all parts of the process based upon their age, developmental stage and identity. Direct work with the child and family should include observations of the interactions between the child and the parents/care givers. Children should be seen alone and their wishes and feelings should be ascertained. If this is not possible or in their best interest, the reason should be recorded.

It is useful to consider:

* The lived experience of the child. What is life like for the child? What are their routines? What kind of care do they receive? What opportunities are they able to access? What are they proud of? What do they keep to themselves?
* What the child thinks about their situation and their views about what has to or could be different;
* The nature of the relationships within the family as experienced by the child.

Where there are concerns about the welfare of a disabled child, they should be acted upon 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](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) as other children.

**1.1 Pre-birth ‘Good Practice Steps’**

In a High Court judgment (Nottingham City Council v LW & Ors [2016] EWHC 11(Fam) (19 February 2016)) Keehan J set out five points of basic and fundamental good practice steps with respect to public law proceedings regarding pre-birth and newly born children and particularly where children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) services are aware at a relatively early stage of the pregnancy.

In respect of assessment, these good practice steps were:

* A risk assessment of the parent(s) should ‘commence immediately upon the social workers being made aware of the mother’s pregnancy’;
* Any assessment should be completed at least 4 weeks before the mother’s expected delivery date;
* The assessment should be updated to take into account relevant events pre – and post delivery where these events could affect an initial conclusion in respect of risk and care planning of the child;
* The assessment should be disclosed upon initial completion to the parents and, if instructed, to their solicitor to give them the opportunity to challenge the Care Plan and risk assessment.

See [**Care and Supervision Proceedings and the Public Law Outline Procedure, Pre-Birth Planning and Proceedings**](https://www.proceduresonline.com/cambspeterborough/cs/p_care_supervis_plo.html#pre_birth_plan) and [**Cambridgeshire and Peterborough Pre-Birth Protocol**](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/pre-birth_assessment/).

**2. Planning for Assessment**

All Child and Family Assessments should be planned and coordinated by a social worker in consultation with the child and family and relevant professionals. The purpose of the assessment should be transparent, understood and agreed by all participants. There should be discussion with the family to explore their perceptions of the assessment and an agreed statement setting out the aims of the assessment process.

Referrals may include siblings or a single child within a sibling group. Where the initial focus for a referral is on one child, other children in the household or family should be equally considered, and the individual circumstances of each assessed and evaluated separately.

Planning should identify the different elements of the assessment including who should be involved. It is good practice to hold a planning meeting to clarify how agencies and professionals can work together to make a contribution to the assessment; and useful for children and family members so they are able to understand the process and their part in it.

Roles and timescales as well as services to be provided during the assessment should be clarified, particularly where there are a number of family members and agencies likely to play a part in the process.

Decision and review points involving the child and family and relevant professionals should be used to keep the assessment on track. The arrangements for these should be part of the planning process.

Where a child is involved in other assessment processes (such as a specialist assessments), it is important that these are coordinated so that the child does not become lost between the different agencies involved and their different procedures. All plans for the child, developed by the various agencies and individual professionals should be joined up so that the child and family experience a single assessment and planning process, which shares a focus on the outcomes for the child.

Questions to be considered in planning assessments include:

* Who will undertake the assessment and what resources will be needed?
* Who in the family will be included and how will they be involved (including absent or wider family and others significant to the child)?
* In what grouping will the child and family members be seen and in what order and where?
* What services are to be provided during the assessment?
* Are there communication needs? If so, what are the specific needs and how they will be met?
* How will the assessment take into account the particular issues faced by black and minority ethnic children and their families, and disabled children and their families?
* What method of collecting information will be used? Are there any tools / questionnaires available?
* What information is already available?
* What other sources of knowledge about the child and family are available and how will other agencies and professionals who know the family be informed and involved?
* How will the [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) of family members be obtained?
* What will be the timescales?
* How will the information be recorded?
* How will it be analysed and who will be involved?
* When will the outcomes be discussed and service planning take place.

The assessment process can be summarised as follows:

* Gathering relevant information;
* Analysing the information and reaching professional judgments;
* Making decisions and planning interventions;
* Intervening, service delivery and/or further assessment;
* Evaluating and reviewing progress.

Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family. A good assessment will monitor and record the impact of any services delivered to the child and family and review the help being delivered. Whilst services may be delivered to a parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/), the assessment should be focused on the needs of the child and on the impact any services are having on the child.

**3. Contribution of the Child and Family**

In all cases, a Genogram should be completed with children and parents or carers at the outset of an assessment.

**The Child**

The child should participate and contribute directly to the assessment process based upon their age, understanding and identity. They should be seen alone and if this is not possible or in their [best interests](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/), the reason should be recorded.

The social worker should work directly with the child in order to understand their views and wishes, including the way in which they behave both with their care givers and in other settings. The use of a range of age appropriate tools can assist social workers in their direct work with children.

The pace of the assessment needs to acknowledge the pace at which the child can contribute. However, this should not be a reason for delay in taking protective action. It is important to understand the resilience of the individual child in their family and community context when planning appropriate services.

Every assessment should be child centred. Where there is a conflict between the needs of the child and those of their parents/carers, decisions should be made in the best interest of the child. The parents/carers should be involved at the earliest opportunity unless to do so would prejudice the safety of the child.

**Parents / Carers**

The parents’ involvement in the assessment will be central to its success. At the outset they need to understand how they can contribute to the process and what needs to change in order to improve the outcomes for the child. The assessment process must be open and transparent for the parents. However, the process should also challenge parents’ statements and behaviour where it is evidenced that there are inconsistencies, questions or obstacles to progress.

All parents or care givers should be involved equally in the assessment and should be supported to participate whilst the welfare of the child must not be overshadowed by parental needs.

There may be exceptions to parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) involvement in cases of Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or forced marriage, or in situations where there may be [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/)or violence where the plan for the assessment must consider the safety of an adult as well as that of the child. See also Peterborough Safeguarding Children Board Procedures: Domestic Violence for further information.

**4. Contribution of Agencies Involved with the Child and Family**

All agencies and professionals involved with the child, and / or family, have a duty to collaborate and share information to safeguard and promote the welfare of the child. All agencies and professionals involved with the child also have a responsibility to contribute to the assessment process. This might take the form of providing written or verbal information in a timely manner and direct or joint work.

Differences of opinion between professionals should be resolved speedily but where this is not possible, the Peterborough Safeguarding Children Board Escalation Procedure should be implemented (see [**Resolving Professional Differences (Escalation) Policy**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/escalation_policy/)).

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

The professionals should be involved from the outset and through the agreed, planned regular review process.

The social worker’s supervisor / Team Manager will have a key role in supporting the practitioner to ensure all relevant agencies are involved.

**5. Developing a Clear Analysis**

A Genogram and a Chronology of previous events should be completed as part of every Child and Family Assessment.

The assessment will involve drawing together and analysing available information from a range of sources, including existing records, and involving and obtaining relevant information from professionals in relevant agencies and others in contact with the child and family. Where an Early Help or specialist assessment has already been completed this information should be used to inform the assessment in order to avoid duplication and repetition for the child and family. The child and family’s history should be understood.

When analysing information gathered during assessment, consideration should be given to:

* Identifying the family’s strengths, resilience and protective factors;
* Identifying any areas of past, current or future risk;
* Explanations for difficulties;
* An exploration of what both children and parents want to be different;
* Clarification of what must be different;
* How this might be achieved;
* What services are in a position to offer this?

The analysis of the assessment should establish:

* The nature of the concern and the impact this has had on the child;
* An analysis of their strengths and needs and/or the nature and level of any risk being suffered by the child;
* How and why the concerns have arisen;
* What the child’s and the family’s needs appear to be and whether the child is a Child in Need;
* Whether the concern involves [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or Neglect; and what extent the impact and influence of wider family and any other adults living in the household has on this, as well as community and environmental circumstances;
* Whether there is any need for any urgent action to protect the child, or any other children in the household or wider community;
* Whether there are any factors that may indicate that the child is being or has been criminally or sexually exploited or trafficked;
* **Note**: if there is a concern with regards to trafficking, a referral into the National Referral Mechanism should be made. See – [**GOV.UK, Human trafficking/modern slavery victims: referral and assessment forms**](https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms).

The social worker should analyse all information gathered to decide the nature and level of the child’s needs and the level of risk, if any, they may be facing. The assessment of risk should consider danger/[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/); safety; strengths; complicating factors and any grey areas.

The supervisor/Team Manager should provide regular supervision and challenge the social worker’s assumptions as part of this process. Critical reflection through supervision should strengthen the analysis in each assessment. An informed decision should be taken on the nature of any action required and which services should be provided. Social workers and other professionals should be mindful of the requirement to understand the level of need and risk in a family from the child’s perspective and ensure action or commission services which will have maximum positive impact on the child’s life. Where there is a conflict of interest, decisions should be made in the child’s [best interests](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/), be rooted in child development, be age-appropriate, and be informed by [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/).

When new information comes to light or circumstances change the child’s needs, any previous conclusions should be updated and critically reviewed to ensure that the child is not overlooked.

Decision and review points involving the child and family and relevant professionals should be used to keep the assessment on track. This is to ensure that help is given in a timely and appropriate way and that the impact of this help is analysed and evaluated in terms of the improved outcomes and welfare of the child.

**6. Actions and Outcomes**

Every assessment should be focused on outcomes, deciding which services and support to provide to deliver improved welfare for the child and reflect the child’s [best interests](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/). In the course of the assessment the social worker and the Consultant Social Worker should determine:

* Is this a Child in Need? (Section 17 Children Act 1989);
* Is there reasonable cause to suspect that this child is suffering, or is likely to suffer, Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)? (Section 47 Children Act 1989);
* Is this a child in need of accommodation? (Section 20 or Section 31A Children Act 1989).

The possible outcomes of the assessment should be decided on by the social worker and the supervisor / Team Manager who should agree a plan of action setting out what services are to be delivered, how and by whom in discussion with the child and family and the professionals involved.

There are a range of possible outcomes which may include:

* No Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) support required but other action may be necessary including:
  + Referral into Early Help provision;
  + Referral into single agency / specialist provision.
* The development of a multi-agency Child in Need Plan, led by Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) for the provision of Child in Need services to promote the child’s health and development;
* Specialist assessment for a more in-depth understanding of the child’s needs and circumstances;
* Undertaking a Strategy Discussion/Meeting, a Section 47 child protection enquiry;
* Emergency action to protect a child.

Following the assessment the social worker should:

* Discuss outcomes with the child and family and provide them with the assessment in written form. Exceptions to this are where this might place a child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or jeopardise an enquiry or [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) investigation;
* Inform in writing, all the relevant agencies of their decisions and if the child is a child in need, of the plan for providing support;
* Inform the referrer of what action has been or will be taken.

**7. Timescales**

The maximum time frame for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than **35 working days from the point of referral**. If, in discussion with a child and their family and other professionals, an assessment exceeds 35 working days the social worker and professionals involved should record the reasons for exceeding the time limit (and the relevant Head of Service notified).

**8. Regular Review of Assessment Process**

Assessments should be timely. The speed with which an assessment is carried out should be determined by the needs of the individual child and the nature and level of any risk or [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) faced by the child.

The assessment plan must set out timescales for the actions to be met and stages of the assessment to progress, which should include regular points to review the assessment. The work with the child and family should ensure that the agreed points are achieved through regular reviews. Where delays or obstacles occur these must be acted on and the assessment plan must be reviewed if any circumstances change for the child.

The social worker’s supervisor / Team Manager must review the assessment plan regularly with the social worker and ensure that actions such as those below have been met:

* There has been direct communication with the child alone and their views and wishes have been recorded and taken into account when providing services;
* There has been observation of the interaction between the child and parent / [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/);
* All the children in the household have been seen and their needs considered;
* The child’s home address has been visited and the child’s bedroom has been seen;
* The parents have been seen and their views and wishes have been recorded and taken into account;
* There is clear analysis and evaluation of the information gathered throughout the assessment process and this has been recorded;
* The assessment provides clear [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) for decisions on what types of services are needed to provide good outcomes for the child and family.

‘Working Together to Safeguard Children’ reminds all professionals of the importance of reviewing progress and that a *high quality assessment is one in which*[*evidence*](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/)*is built and revised throughout the process and takes account of family history and the child’s experience of cumulative*[*abuse*](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)*. A social worker may arrive at a judgement early in the case but this may need to be revised as the case progresses and further information comes to light. It is a characteristic of skilled practice that social workers revisit their assumptions in the light of new*[*evidence*](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/)*and take action to revise their decisions in the*[*best interests*](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/)*of the individual child.* Decision points and review points involving the child and family and relevant practitioners should be used to keep the assessment on track. This is to ensure that help is given in a timely and appropriate way and that the impact of this help is analysed and evaluated in terms of the improved outcomes and welfare of the child.

**9. Recording**

Recording by all professionals should include information on the child’s development so that progress can be monitored to ensure their outcomes are improving. This is particularly significant in circumstances where neglect is an issue. Recording should include when the child was seen alone and their wishes and feelings and how they have impacted on recommendations, decisions and plans.

Records should be kept of the progress of the assessment on the individual child’s record and in their Chronology to monitor any patterns of concerns.

Assessment plans and action points arising from meetings should be circulated to the participants including the child, if appropriate, and the parents.

Recording should be such that a child, requesting to access their records, could easily understand the process taking place and the reasons for decisions and actions taken.

Supervision records and/or case discussion recordings should reflect the reasoning for decisions and actions taken.

**10. Principles of a Good Assessment**

The Assessment Framework triangle in Working Together to Safeguard Children provides a model, which should be used to examine how the different aspects of the child’s life and context interact and impact on the child. It notes that it is important that:

*“Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family. It is important that the impact of what is happening to a child is clearly identified and that information is gathered, recorded and checked systematically, and discussed with the child and their parents/carers where appropriate.”*

**11. Contextual Safeguarding**

As well as threats to the welfare of children from within their families, children may be vulnerable to [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online.

These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as [county lines](https://www.safeguardingcambspeterborough.org.uk/glossary/county-lines/); trafficking, online [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/); sexual exploitation and the influences of extremism leading to radicalisation.

Assessments of children in such cases should consider whether wider environmental factors are undermining effective intervention being undertaken to reduce risk with the child and family. Parents and carers have little influence over the contexts in which the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) takes place and the young person’s experiences of this extra-familial [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) can undermine parent-child relationships.

Where this is the case, the social worker should:

1. Refer the child’s circumstances to relevant Multi-Agency work which addresses the concerns and risks in the neighbourhood or local authority;
2. Identify the issues with their line-manager with a view to the local authority establishing a multi-agency intervention programme to meet community needs; or
3. In specific circumstances, through their line-manager, seek to convene a Child in Need strategy/planning meeting with relevant partner agencies (e.g. school, [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), relevant voluntary bodies, etc.) to explore specific interventions to address the safeguarding issues.

Within this context, children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare.

Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents and carers to understand any risks and support them to keep children safe and assess potential risk to the child.

These interventions should focus on addressing both child and family and these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

**Appendix A: Assessment Triangle**

The Assessment Triangle and the Domains and Dimensions of the Assessment Framework are intended as a reminder to professionals undertaking the assessment and to be given to parents to help them understand the areas the worker will want to explore. It is good practice to give a blank copy of the Assessment Record to parents on first meeting them to enable them to understand and participate in the process.

Diagram

Description automatically generated

*“Developing a detailed understanding of a child’s needs, identity and*[*best interests*](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/)*enables us to take the actions required to meet and fulfil them.”*

**(Sir William Utting ‘The care of children: Principles & Practice in Regulations and Guidance’ 1989)**

**Appendix B: Domains and Dimensions**

**CHILD’S DEVELOPMENTAL NEEDS**

**Health**

Includes growth and development as well as physical and mental well-being. The impact of genetic factors and of any impairment should 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 have access to books; to acquire a range of skills and interests; 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 child’s growing understanding of the way in which appearance, behaviour, and any impairment are perceived buy 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.

**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](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or danger.

Includes protection from significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or danger, and from contact with unsafe adults/others children and from self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). Recognition of hazards and danger both in the home and elsewhere.

**Emotional Warmth**

Ensuring the child’s emotional needs are met and 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 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 problems 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.

**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; the relationship between separated parents.

**Wider Family**

Who are considered to be members of the wider family by the child and the parents?

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, their 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, accessibility and standard of resources and impact on the family, including disabled members.

**Child death**

**1.1 Introduction – The Joint Agency Response****[[1]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn1)**

The Cambridgeshire and Peterborough Safeguarding Partnership have adopted this protocol.  Its purpose is to support professionals and organisations to work together in a coordinated way when a child has died unexpectedly. The document ‘*Protocol and Terms of Reference for the Child Death Overview Panel for Cambridgeshire and Peterborough Safeguarding Children Board* details how information about all child deaths in Cambridgeshire and Peterborough are collated and analysed by the Child Death Overview Panel.  All professionals should follow the protocol in collaboration with relevant agency specific policies, procedures, and protocols.

This protocol details the operational ‘Rapid Response Process’ ‘which should be initiated when a child dies unexpectedly’. The unexpected death of a child is traumatic for everyone involved. The family will experience extreme grief and shock and professionals will need to support them sensitively. Unexpected deaths must be fully investigated to identify contributory factors and prevent future deaths. The investigation needs to balance medical management with care and support of the family, potential safeguarding concerns and an understanding of the cause of death.

**1.2 Aims**

Professionals need to work together in a coordinated way to:

* Establish the cause of death including whether a crime has occurred
* Support the family
* Identify contributory factors which might prevent future deaths
* Gather information to contribute to the Child Death Overview Panel arrangements
* Identify potential safeguarding concerns

Knowing how and why a child died may offer comfort to parents and families and lessen a natural tendency to blame themselves. Professionals who understand about contributory factors may be able to use this information to prevent future deaths.

Over 5000[[2]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn2) children die in the UK each year, a very small number of these will have a malicious or non-accidental cause.  Examining all childhood deaths will help to highlight these cases and help inform the Department of Health about the risk factors.

The Safeguarding Childrens Partnerships have a responsibility to ensure a coordinated response by partner agencies to the unexpected death of a child. Together with reviewing all child deaths, this information can advise local strategic planning about the modifiable factors, which may prevent future deaths.

**1.3 Processes**

**1.4 Statutory Implications**

The protocol is based on the guidance in Chapter 5 of Working Together to Safeguard Children: July 2018; and following the principles of *Sudden and Unexpected Death in Infancy and Childhood, multi-agency guidelines for care and investigation 2016*

**1.5 Definitions**

**Child.**

All young people who have not yet reached their 18th birthday, including those living independently, in further education, employment, a member of the armed services, in hospital, in prison or a Young Offenders Institute.  It includes the death of all children where a birth certificate has been issued but excludes all planned terminations. It includes the case of stillbirth where no healthcare professional was in attendance.

**Parent.**

The adult or adults with legal “care and control” of the child at the time of death with ‘parental responsibility’ (PR) for the child.  PR may be shared with the Local Authority through a care order or given to an adult through legal process such as adoption.  Any person with PR whether caring for the child or not at the time of death will be deemed to be a ‘parent’.

**Sudden Infant Death Syndrome (SIDS).**

The sudden death of an infant less than one year of age, which remains unexplained following thorough case investigation, including complete autopsy, examination of the death scene and a review of the clinical history.

**Sudden Unexpected Death in Childhood (SUDC).**

The sudden death of a child over 1 year, up to 18 years, which was not anticipated as a significant possibility 24 hours before death.  Alternatively, where there was an unexpected collapse leading to, or precipitating, the events that led to the death.[[3]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn3)

**Sudden Unexpected Death in Infancy (SUDI).**

The sudden unexpected death of a child under the age of 12 months.

**2. Responsibilities**

**2.1 Joint responsibilities**

Agencies are required to identify staff to undertake their normal tasks as well as working together as a multiagency team following the death of a child. This team will be coordinated by either a [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) officer or health professional:

* Ensuring that bereaved families are treated with sensitivity and respect, offered appropriate support and kept fully informed
* Adopting an open minded and proportionate and professional approach to circumstances
* Ensuring that [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) is preserved (such as the last nappy) and that the death is thoroughly investigated
* Providing a prompt response and ensuring that the investigation is completed expeditiously
* Respond quickly to the unexpected death of a child.
* Undertake immediate enquiries into the death and evaluate and interpret the available information.
* Make enquiries or investigations, which relate to the responsibilities of their organisations when a child dies unexpectedly including liaising with those who have ongoing responsibilities for surviving family members, (particularly siblings)
* Collect information to inform the Coronial process.
* Collect information for the Child Death Review process
* Maintain close liaison with family members and other professionals working with surviving family; ensure they are apprised of results of enquiries. This should be done by a named keyworker.
* On occasion, it might be appropriate to seek [consent](https://safeguardingcambspeterborough.org.uk/glossary/consent/) to examine family members’ medical notes.
* Cooperate with an investigation by the Prisons and Probation Ombudsman if the child died in custody (or by the Independent [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) Complaints Commission in the case of [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) custody)

**2.2 Evidence of Criminality**

In most situations’ professionals will have no reason to suspect a death involves a criminal act.  However, should there be **any** suspicion a child has died from an unlawful act, then the presumption shall be that the child’s body and the place of death are both crime scenes.  These will need to be secured pending the arrival of a [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) Senior Investigating Officer.  Whilst every effort will always be made to resuscitate a child, if it is clear no medical intervention can help, the crime scenes must be secured as soon as possible.

If a criminal act is suspected, immediate consideration must be given to whether or not there are other children e.g. siblings who may require safeguarding and a referral made to children’s [social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/).

**2.3 Notifications to Coroners**

The Coroner must be notified of a body lying within his jurisdiction when:[[4]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn4)

* The child died a violent or unnatural death.
* The death was sudden death or of unknown cause.
* The child died in prison.

A body cannot be moved across jurisdiction boundaries without the coroner’s permission.  However, with prior permission Coroners will accept the removal of a body to an Emergency Department in accordance with this protocol.

The Coroner must be notified by the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) or attending clinician depending on circumstances of death.  Both must assure themselves that the notification has been made or undertake the notification themselves.

All information about the circumstances of the death, including a review of all medical, social and education records, must be included in the report for the Coroner.

**2.4 Record Keeping**

Records are essential to the learning process, underpinning decision making and potentially for court proceedings; therefore, accurate records must be kept of all tasks undertaken as directed by this protocol.

* Decisions must be recorded, together with reasons.
* All records must be legible, timed, dated and signed by the author.
* A record of what was said by parents and carers will need to be made and remarks attributed to a named person.
* Opinion needs to be distinguished from fact.

**2.5 Coordination of Rapid Response**

* The Child Death Review (see 1) notes the ‘Designated Paediatrician with responsibility for unexpected deaths in childhood’ has lead responsibility for most of the processes detailed in the guidance. This is set out in 3.7
* The CDOP Manager will support the Designated Paediatrician in ensuring that the child death review arrangements are followed.
* All agencies that have been involved with the child (before and after death) are expected to cooperate fully with the coordinator and the lead professional for the Joint Agency Response process.

**2.6 Individual Agency Responsibility**

Individual agencies are encouraged to develop compatible guidance for their staff.  This should be ratified by the Child Death Overview Panel to ensure that it is compatible and consistent with this protocol.

**2.7 Adjoining Counties**

Occasionally children from Cambridgeshire or Peterborough are cared for, or hospitalised “out of County”, alternatively a child “out of County” is transferred to a Cambridgeshire or Peterborough hospital or carers. The principle to be followed is, whilst for the Coroner the place of death determines responsibility, it is the child’s usual home address which determines the responsible authority for the Child Death Review Process.  When an unexpected child death occurs within the Cambridgeshire and Peterborough area, the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) will be responsible for the initial notification of the death to the home area.  Subsequently the CDOP Manager will liaise as appropriate.

In order to avoid omission notification to home CDOP. Agencies should err towards duplication of notification: to both Home CDOP and CDOP local to the place of death.

**3. Responding to the unexpected death of a child**

**3.1 General Principles**

This protocol cannot predict all circumstances relevant to an individual death; rather it sets out guidelines and principles to follow as circumstances dictate.  However, staff must be mindful that most of this guidance is statutory, therefore departures from it will need to be documented with a rationale.

The principles applied are.

* This protocol is applicable to unexpected deaths in children, of any natural, unnatural or unknown cause, at home, in hospital or in the community.
* It excludes those babies who are stillborn (where a medical professional was present) confirmed and planned terminations of pregnancy carried out within the law.
* Where the cause of death is obvious, e.g. a road traffic collision, some consideration should be given to the events leading up to the death; for example, a young unsupervised child who is killed may need further investigation.
* Children with Life Limiting or Life Threatening (LL/LT) conditions are as valued and important as any other child. The application of this protocol should be considered, and the response should be appropriate and supportive.

The protocol is applicable for deaths of children across the Cambridgeshire and Peterborough area, irrespective of their home address. The Children and Social Work Act 2017 Legislation allows for Child Death Review (CDR) partners to make arrangements for the review of a death in their area of a child not normally resident there.  A pragmatic approach should be taken to such deaths, entailing discussion between the CDR partners in the area where the child is normally resident and those in the area where the child died. In all cases, the CDR partners in the area where the child is normally resident is responsible for ensuring that a review *takes place* at CDOP level.  Consideration should also be given to where the most learning can take place, and this may sometimes dictate that a different CDOP to the area where the child is normally resident leads the discussion.

* To achieve a balance between forensic and medical requirements with the family’s need for support.
* Children with an existing disability or medical condition where the death is not anticipated, have the same level of review as any other child.
* If a death is anticipated due to a known illness, it should only be subject to this protocol **if there are reasons to be concerned about the circumstances of their death.**
* If [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect is suspected as a cause of death or as a contributory factor, immediate consideration must be given to the safety of siblings.

**3.2 First Response, Ambulance staff, GP, Fire & rescue**

At the scene of an unexpected death, the first responsibility is the preservation of life; the second is a duty to safeguard other children. Resuscitation should always be initiated unless it is inappropriate to do so because resuscitation is clearly futile.  Ambulance staff should:

* Attempt resuscitation in all cases unless there is a condition unequivocally associated with death or a valid advance directive. That is, do not automatically assume death has occurred.
* Clear the airway and, if in any doubt about death, apply full Cardiopulmonary Resuscitation.
* Inform Emergency Department of estimated time of arrival and patient condition.
* Take notes about how body was found, including anomalies/inconsistencies of accounts and marks/injuries and discuss these with the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/).
* Deaths which are clearly due to suicide, road traffic accidents or non-suspicious trauma: – bodies should be taken to the appropriate place, such as the mortuary.

Where resuscitation is clearly inappropriate it is usually still desirable to take the child to hospital. The only exception to this may be the designation by the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) of a crime scene.

Most other actions from this protocol follow the child’s removal to an emergency department in the hospital.

**3.3 Hospital Staff in Emergency Department**

Most children will be taken to the nearest emergency department.  The Emergency department staff will be responsible for assembling a resuscitation team, including on call paediatric staff for children under the age of 16 and to promote ongoing care and family support.  On arrival at ED.

* All information gathered by the Ambulance crew or GP should be shared with the medical staff taking over responsibility for the child.
* On arrival the child should be taken to an appropriate room for the continuation of resuscitation if appropriate. However, if the Child is dead then this is declared.
* Parents should be given the choice of remaining with their child whilst resuscitation is attempted or be allowed to go to a private room and be kept fully informed as to what is taking place.
* Staff should be sensitive to the needs of the parents and ensure they refer to the child by name and in the present tense.
* If possible, a nurse is appointed to act as an interface between the family and the medical team attending to the child and to support them through the process at the hospital when the child dies.
* If possible, the Doctor in charge will consult with parents about deciding how long resuscitation should continue.
* If there are suspicions that the child died from an unlawful act, immediate consideration should be given to the need to safeguard any remaining siblings and [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) must be contacted immediately.

**3.4 Assessment and Investigation following admission to the Emergency Department**

In all cases:

* A senior doctor should take a detailed and careful history of events leading up to and immediately prior to death. See practice note in Appendix B for details. If the Senior Investigative Officer (SIO) is at the hospital, consideration should be given to a joint interview where appropriate. This should not delay the taking of a history from parents / carers.
* Medical notes should record conversations with parents with particular attention paid to ensuring which comments are attributable to which parent. Ideally contemporaneous notes with a verbatim account should be documented.
* A thorough examination of the body by a senior doctor should take place with the examination findings recorded on a body chart (including any post mortem changes), unless agreed between lead health professional and lead investigating [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) officer, for example if it is a death which is clearly suicide, road traffic accident or non-suspicious massive trauma. If the SIO is at the hospital, consideration should be given for this to take place with the SIO present. This should not delay examination of the body. A clear example of where this should happen would be SUDI.
* Responsibility for notifying the Coroner will fall to the doctor confirming death or the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) (SIO).

In a SUDI case the following specimens must be taken.

* Nasopharyngeal Aspirate – Virology to be taken in ED
* Pharyngeal swab – Microbiology to be taken in ED

Plus, the following sample may be taken.

* Additional samples as approved by the Coroner according to local protocols – See appendix A and B. Essentially this would constitute one attempt at a lumbar puncture and a cardiac stab for blood cultures, with an expectation that the pathologist would undertake any other necessary investigations at post-mortem.
* As with all clinical scenarios – it is the role of the doctor to try to make a diagnosis. If specific tests are suggested by the history and/or examination (which are not otherwise covered above), then these may be undertaken, particularly if it is thought that deferring the tests to post-mortem might be clinically unhelpful. An example of this might be a high suspicion of an inherited metabolic disorder.

Any further investigations should only be commissioned following the initial case management discussion to meet an identified investigative or clinical need.

**3.5 Family Support**

When the child has been pronounced dead and resuscitation has discontinued.

* The most appropriate senior clinician should firstly review all available information, and then break the news to the family. The news should be delivered in a private room with the allocated nurse present.
* Intravenous cannula, endotracheal tubes and other equipment may be removed from the child, but this should be documented clearly in the notes and countersigned by staff member to confirm that the items were removed as documented in the notes. The counter signatory should be a fellow professional not involved in the immediate care of the child.
* Any nappies or clothing should be removed and sealed in a plastic bag and should accompany the body to the mortuary.
* The child’s face should be cleaned, and the child dressed in a clean nappy and wrapped in a shawl or blanket.
* The parents should be allowed to hold their child, unless the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) object to the proposal.
* Ask parents if they wish to have a footprint/handprint or a lock of hair by way of a keepsake. This should be offered early but made clear to parents that they may not be able to receive this straight away. Whilst such a hair sample would technically be a sample under the Human Tissue Act (2004), common sense should prevail, but in all cases it will be necessary to discuss with the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and Coroner who will endeavour to meet reasonable requests wherever practicable. Care needs to be taken to handle the child gently.
* In rare cases when deliberate [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/) is suspected DO NOT take hand or footprints, the pathologist will do this later on request.
* If the family request that the baby be bathed for cultural reasons, permission should be gained from the SIO and Coroner before agreement.
* The family should be advised the death will be reported to the Coroner and that for all unexpected deaths a post-mortem examination may be carried out. The family should be informed that the cause of death will not be known until after the results of the post-mortem are analysed.
* At this point the family should be given relevant information depending on the age of the child including
  + for infants – Lullaby Trust leaflet
  + for all children the CDOP leaflet “the child death review”

See Appendix C for contact details for bereavement organisations. Each hospital has its own bereavement department.

**3.6 Role of Health professionals**

**3.6.1 On call Health Professional**

If a child dies unexpectedly at home or non-hospital setting, the professional confirming death should contact the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) at the earliest opportunity through calling the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) control room on 101. If there are concerns that the death may be suspicious 999 should be called. As soon as possible, the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) should follow the protocol above and make telephone contact with the health professional named on the on-call rota.  Between the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and the health professional they will identify the person to instigate the information sharing meeting, home visit and information collection and provide support to family.  If it is decided a home visit will not take place, then the reason for this is taken at the information sharing meeting and recorded.

If there are suspicions the child had died from an unlawful act, the scene must be secured at the earliest opportunity, and ‘handed over’ to the first [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/)officer to attend.  Any suspicions must be reported to the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and the receiving Doctor in the ED at the earliest opportunity.

The health professional on the on-call rota for unexpected death in childhood will be a senior health professional with appropriate knowledge and training.

The on-call period for phone cover is between 8am and 8pm each day including weekends and bank holidays with home visits carried out between 9am and 5pm. The frequency of being on-call is determined by the number of health professionals engaged in this process.

The on-call health professional is to liaise with the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) SIO as soon as possible once they become aware of an unexpected death of a child, irrespective of where the information came from.  The purpose of this discussion is to share information regarding the death and identity of the child, to discuss the planning of a joint scene of death visit with the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and discussion with the parents. The health professional also needs to inform the CDOP Manager via the eCDOP public site: <https://www.ecdop.co.uk/CambridgeshirePeterborough/Live/Public> as soon as possible to enable further gathering of information and continuity of the process. The eCDOP system uses the statutory forms and process from the Working Together 2018 guidance and assists safeguarding teams to ensure compliance. The eCDOP system automatically transfers data at each relevant stage of the process into the National Child Mortality Database (NCMD). This information is then used to analyse data nationally in order to improve learning and implement strategic improvements in health care for children in England, with the overall goal to reduce child mortality. There may be a need to attend a child protection strategy meeting if required.  See section 4.0 for further details on scene of death visit.

Record management must be factual, completed contemporaneously, signed and dated. Documentation completed following a scene of death visit and discussion with the parents must be shared with the pathologist within 24 hours of the visit if during the working week.  Form B should also be completed and sent to the CDOP Manager. This will be requested by them via eCDOP.

**3.6.2 Designated Doctor for Child Death**

The Designated Doctor for Child Death is at the heart of this process. In Cambridgeshire and Peterborough parts of this role may be delegated to the health professionals on the rapid response on call rota.  The responsibilities include ensuring systems are in place to:

* Advise the CCG on commissioning clinicians with expertise in undertaking enquiries into unexplained deaths plus availability of relevant investigative services of radiology, laboratory and histopathology services.
* Coordinate the team to respond to each unexpected child death in accordance with this protocol.
* Liaise with the consultant clinician dealing with the death.
* Ensure relevant professionals are informed of the death and begin to gather information (e.g.: [police](https://safeguardingcambspeterborough.org.uk/glossary/police/), [social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/), GP, health visitor or school nurse).
* Convene multi-agency case discussions potentially by phone when initial post-mortem results are available.
* Ensure appropriate attendance at the multi-agency case discussions when the final post-mortem results are known and ensure that the collection of information is completed for the data set form C.
* Support the CDOP chair and the panel to deliver the rapid response protocols; identify training and communication needs across Cambridgeshire and Peterborough for professional staff.

**3.6.2 Senior clinician dealing with the death**

The Senior clinician dealing with the death (Consultant Paediatrician or ED Consultant, usually the former for children under 16 years old) has responsibility to:

* Provide clinical care.
* Examine the child’s body (see appendix A and B)
* Take a detailed history of events leading up to and following the child’s death from the parents. Review all available information. Fully record all information.
* Inform the parents about the death.
* If appropriate, inform parents a post-mortem will be carried out and that a Coroner’s officer will be contacting them with more information.
* Liaise with the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) about the death.
* Initial information sharing with relevant agencies as soon as possible:
  + other health professionals e.g. GP, professional certifying death
  + local authority children’s services ([social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/))
  + Child health records
  + Consider a referral to Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) if there are child protection concerns

**3.7 Role of Police**

National Guidance [[](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn5)a] requires an Officer of at least the rank of Detective Inspector to attend all reported cases of sudden and unexpected deaths of infants.  Within Cambridgeshire Constabulary this falls to a Detective Inspector or above, who has undergone specific training to ensure they are equipped with the appropriate skills and knowledge to lead, manage and guide the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) response and investigation into the sudden unexpected death of a child. Every report of the unexpected child death received by [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) will immediately be allocated to one of the specialists ‘on call’ Senior Investigative Officers (SIO) who has responsibility to respond to such incidents.

The specialist ‘on call’ SIO will be advised by the Force Control Room whenever they receive a report of a sudden unexpected child death.  The SIO will attend the scene and/or the Accident and Emergency Department as circumstances require – but they will always be contactable via the Force Control Room (01480 426001 Duty Control Room Inspector – restricted number) in any circumstance where this protocol applies.

The SIO has responsibility for conducting a large number of ‘fast track actions’ in order to manage the initial stages of the investigation into understanding why the child died.  It is important that other partners are aware of these actions since they may be asked to assist in the discharge of these actions or, alternatively, they may benefit from knowing the nature of the information the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) will be collecting.

The SIO will contact the health professional on the Rapid Response on-call rota as soon as is practicable. The purpose is to instigate the Rapid Response procedure, informing Health of the child’s death and to coordinate where applicable a visit jointly performed by health and [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) professionals to the scene of death.  If this joint visit does not occur, the rationale for this decision will be documented and reported at the information sharing and management meeting.  If further clarity is needed, the Designated Paediatrician with responsibility for the unexpected deaths in childhood process should be contacted during working hours.

**3.8 Role of Coroner’s Officers**

Coroners Officers have knowledge of the Coronial system and involvement with families when a child has died unexpectedly. They have a valuable contribution to the information sharing process and assist and advise with the management of samples and investigations. Once the post-mortem report is available, the Coroner’s Officer will share the findings with the parents, unless the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) request otherwise.

**3.9 Role of Coroner and Pathologist**

After death the Coroner has control of the body and mementoes/medical samples must not be taken without their approval.

The post-mortem will be carried out using either a specialist paediatric pathologist or a Home Office forensic pathologist. If the Coroner is concerned about the nature of the death, he may instruct that both a paediatric pathologist and a Home Office pathologist carry out the post-mortem.  The Coroner has the choice of pathologist.[[5]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn6)  If during the post-mortem the paediatric pathologist becomes concerned about suspicious circumstances, they must halt the post-mortem and, with the Coroner’s authority, arrange for contact to be made with a Home Office pathologist. The [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) must also be notified immediately.

The Coroner’s Officer will ensure that all relevant professionals are advised of the time/date/location of the post-mortem. The SIO will arrange for a Scenes of Crime Officer (SOCO) and an exhibits officer, if relevant, to also attend if the post-mortem is being carried out by/with a Home Office pathologist.  The Coroner’s Officer will also advise the parents of the post-mortem details and the right to be represented at the post-mortem.

It is very important that the Pathologist receives a detailed history of the case in advance of the post-mortem examination.  As a minimum the ‘History Record’ should be provided to the pathologist.  However, the Paediatrician and the SIO are also expected to notify the Pathologist of all and any matters that may be germane to the child’s death. This might mean in some instances that a phone call/email will suffice; in other instances, it might mean that photographs or video recordings are made available to the Pathologist.

At the post-mortem the pathologist will arrange a number of investigations to be carried out. This will include a full skeletal survey for infants and the collection of samples for microbiology and metabolic investigations. This can only be done with the [consent](https://safeguardingcambspeterborough.org.uk/glossary/consent/) of the Coroner and must be only to ascertain the cause of death. The only exception is where the samples are taken by the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) under the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and Criminal [Evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) Act (PACE). If the Paediatrician has commissioned any investigations prior to death the pathologist will need to be advised and the results forwarded to him/her when known.

See appendix A and B for details of specimens to be taken ED.

This protocol supports the Royal College of Pathologists’ ‘Guidelines on Autopsy Practice’ (2002), which state that:[[6]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn7)

* A provisional report (to include a preliminary cause of death where possible) should be sent out within 5 working days of the examination.
* Where there are no complex investigations the complete report should be sent out within one week of the examination.
* Results of further investigations with a commentary or conclusions and the stated cause of death should be sent out within one week of availability of those findings.

The provisional report to the Coroner will also include details of retained samples. Under Rule 10(1) Coroners Rules 1984, the person undertaking the post-mortem must report to the Coroner.  This means that the report will always be forwarded to the Coroner in the first instance, and only at his/her discretion will it be shared with partners. In practice, local Coroners will allow the post-mortem report to be shared with the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/), CDOP Manager and Designated Doctor for Child Deaths once he/she has had an opportunity to review the findings and decide on any further course of action.

**3.10 Role of Local Authority**

**3.10.1 Social Care**

It is important that [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) are consulted at the beginning of this process to ascertain any prior knowledge of the child, siblings and family.  If the family are known to [social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) or there are concerns regarding the needs or safety of other children [social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) will be involved in the multi-agency case management discussion. The [Emergency Duty Team](https://safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/) should be notified of the unexpected death out of hours (01733 234724) and the normal referral process for [social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) should followed during daytime hours.

The level of involvement will differ markedly dependant on the circumstances, the case history and any safeguarding issues raised in respect of the siblings. If there are concerns about deliberate [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/), [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) must be contacted immediately in order to ensure the safety of remaining siblings.

**3.10.2 Education**

Education services will be involved in the case management discussions if the child or siblings are of school age.

Other children and adult services may also be required to have input into the multi-agency response (e.g. mental health or substance misuse workers, early years, children centres, the Youth Offending Service etc).

**4. Multi agency response**

**4.1 General**

So far, the protocol has detailed the actions of professionals who attend when a child is found dying or dead and the actions to be followed when the child is received at the Emergency Department.

Once the death has been confirmed, any specimens or samples taken and the history has been taken, the following also need to be done.

**4.2 Informing the Co-ordinator for Child Death Overview Panel (CDOP) Arrangements**

The Safeguarding Childrens Partnership must be informed about the child death via the CDOP Manager. A Form A Notification must be sent via the eCDOP public site:  <https://www.ecdop.co.uk/CambridgeshirePeterborough/Live/Public>

From this point the Child Death Review Form B should be used to collect relevant details.  See Safeguarding Childrens Partnership ‘Protocol and Terms of Reference for the Child Death Overview Panel for Cambridgeshire and Peterborough Safeguarding Childrens Partnership’.[[7]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn8)

* The decision to undertake a home visit should be agreed between the Protecting Vulnerable People directorate or Duty Detective Inspector and the on-call Rapid Response paediatrician during   on-call hours. A visit would normally occur in SUDI cases or where it was agreed that it would likely yield valuable information regarding cause of death, or with safeguarding considerations.
* The initial scene of death visit is most commonly at the home of the child but may not be. However, the visit is an essential part of the multi-agency investigation into an unexpected child death to establish the circumstances of death especially if a child has died in a non-hospital setting.
* If the scene of death has been designated as a crime scene by the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) a joint visit should not automatically be precluded but should be given careful consideration.
* Prior to the visit the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) Officer and Health professional should exchange any known information about the child and family, and plan how to conduct the visit. It is essential that any records completed surrounding the incident and particularly the recent health records are accessed.  This will prevent duplication of questions to the bereaved parents/carers.
* It is possible for the visit to take place in two parts; if the family are not present at the scene of death and / or do not wish to return there the interview can take place in their current location and the scene of death  assessed separately.
* The visit should almost always take place if a child is under 12 months.
* This is joint health/[police](https://safeguardingcambspeterborough.org.uk/glossary/police/) (SIO trained) visit and should take place as soon as possible after death is confirmed.
* Information from this visit or the reasoning for not completing a scene of death visit must be shared with the pathologist (when a post-mortem is to be undertaken), the health coordinating team and the CDOP Co-ordinator. Please see appendix F for further guidance on when a home visit is indicated.
* If there has been a section 47 strategy meeting, discussion must take place within Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) about whether a scene of death visit is appropriate.

**4.4 Plan of Scene of death visit**

The purpose of this visit and the discussion with the parents include the following and rely on the skills and knowledge of both the [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and health professionals:

* To complete and clarify the history of events.
* Use of health knowledge and understanding of child development and childhood illnesses and their likely causes.
* Identify and contextualise factors that may have contributed to death.
* To provide information and support to the family.
* To identify [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) that implies suspicious circumstances.
* To identify inconsistencies in history.
* To record observations on sleep environment.
* To consider video recording the environment for the benefit of the pathologist – not for evidential purposes.
* To ensure appropriate handling of [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/).
* To ensure legal provisions (principally PACE 1984) are observed.
* Room measurements would usually be the prerogative of the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) / SOCO. Exact measurements of room temperature will not normally need to be taken but a comment if the room is excessively hot or cold can be added to the observations.

Both [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and Paediatrician are required to use the Safeguarding Childrens Partnership Form B to record findings to date.

**4.5 Initial Case Management Discussion**

Information sharing is vital; therefore, the appropriate health professional, [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) participate in an Initial Case Management Discussion, within 12 hours of the death being confirmed. This may be a meeting or telephone conference. Agreed actions and who is responsible for them must be recorded and forwarded to the CDOP Manager. Information should be shared on the following:

* background information/presentation of child
* background information regarding child/siblings/carers
* safeguarding issues of surviving siblings
* immediate Child Protection issues
* nature of any suspicions
* consider request of blood samples from parents/carers
* scene management
* contact with Coroner
* timing of PM and briefing of pathologist
* restrictions on viewing of body
* significant [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) action (arrests, statements)
* immediate support for bereaved – deployment of Family Liaison Officer
* coordination of Professionals Contact with family – home visit
* agreed point of contact with mortuary and Bereavement staff
* status of enquiry/investigation – criminal / child in need or child in need of protection.
* time and date of SUDI case meeting
* press strategy
* staff Welfare
* notification to CDOP Manager

Where there is a criminal investigation initiated the sharing and disclosure of information remains a key element in the process of the investigation into the child’s death and the meeting should still be held face to face with detailed minutes being taken. Each party at that meeting will be advised that there is a potential that any information shared could be used at a later date in a criminal court. The [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) may withhold information from the meeting in order to protect the integrity of any [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) gathered as long as in doing so it does not pose a threat to the health and [wellbeing](https://safeguardingcambspeterborough.org.uk/glossary/wellbeing/) of anyone or is detrimental to the decision making process relating to the safeguarding of siblings or other children.

If a referral has not already been made, and it is the view of this meeting that [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect is a factor in the death a referral must be made to social services for a Section 47 Child Protection Enquiry, and then to the Safeguarding Childrens Partnership for consideration by the Serious Case Review Panel.

This meeting must be minuted.

**4.6 Second Case Management Discussion**

The second case discussion is to be convened shortly after the initial post-mortem results become available. This may be by telephone and possibly not be needed for all unexpected deaths but should occur when the preliminary results of the post-mortem are available. The meeting will be organised by the CDOP Manager. All known professionals who have knowledge of the family will be invited and it will be convened in a venue suitable for the majority of the professionals.

The aim of this meeting is to consider any child protection or other needs of surviving children and any other children; ensure the bereavement needs of the family are addressed and any contributing factors to the death identified.

To facilitate this, the meeting will review the information and the actions of the initial discussion and gather detailed information from other professionals. The meeting will be minuted and any key actions identified to form a plan which will be reviewed at the final case discussion. A copy of the minutes taken will be distributed to all professionals involved, including the Coroner. A provisional date for the third case discussion meeting is made for 12 weeks’ time.

Agenda

**Information Sharing and Bereavement Planning Meeting**

**(Agenda for Chair and minute taker)**

|  |  |
| --- | --- |
| 1. | Introductions and Apologies |
| 2. | Purpose of meeting  To share information, co-ordinate a bereavement plan for the family and identify whether there are any safeguarding concerns. Explanation of rapid response process. |
| 3. | Information Sharing |
| 4. | Safeguarding Risks / Issues?  This needs to be minuted even if there are none. |
| 5. | Bereavement plan  A named lead person to support the family should be identified rather than a professional’s title. |
| 6. | Communication with the family  §  The Coroner’s officer is responsible for informing parents of the post-mortem results. Consider if parents would like support from a known (health) professional for this.  §  Have parents been given leaflets, have they been informed of this meeting / further process and CDOP |
| 7. | Notification of Other Agencies  Ensure all relevant agencies / professionals have been notified of the child’s death |
| 8. | Serious Case Review consideration  Do those present feel criteria are met for a SCR? |
| 9. | Final report to Child Death Review Committee  Explain further process: final case discussion, completion of form C, CDOP panel |
| 10. | Future Meetings (usually held approx. 6-8 weeks after initial meeting)  Set a date for the final case discussion, date to be confirmed when post-mortem results received. |

**4.7 Third Case Management Discussion**

This may be held when the final post-mortem results are known.[[8]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftn9)  This will normally be a meeting not a telephone discussion, however some flexibility is allowed given the differences between cases.  Where the post-mortem provides a conclusive cause of death with no contributory factors and little potential for learning, no meeting is necessary. Otherwise parties will meet for the third case management discussion which is arranged and chaired by the designated professional or by a member of the Rapid Response team.

There needs to be an explicit discussion about the possibility of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect either causing or contributing to death.  If no [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) of maltreatment is identified the minutes shall record this.

The minutes of this meeting will be in the completion of the Form C, *Analysis Proforma* with the approval of all attendees then sent to the Coroner.

If it is the view of this meeting that [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/), or neglect is a factor in the death a referral must be made to the relevant Safeguarding Childrens Partnership Serious Case Review Panel.

**5. Governance**

**5.1 Safeguarding Childrens Partnership Audit Responsibilities**

The Cambridgeshire Safeguarding Childrens Partnership and Peterborough Safeguarding Childrens Partnership will:

* Observe the statutory obligations within Chapter 5 of Working Together to Safeguard Children 2015
* Monitor and review audits, to comply with DFE data collection and to demonstrate the protocol is being followed.
* Receive a report on a regular basis from CDOP

**5.2 Accountability**

Partner organisations will be accountable to the Safeguarding Childrens Partnerships for their organisation meeting its responsibilities under this protocol through representation on CDOP.

Accountability will be with named posts not an individual.  To carry out its statutory child death review function, the Safeguarding Childrens Partnerships need to be informed of any changes to the identified posts.  Therefore, the following agencies are required to inform the Safeguarding Childrens Partnership Coordinator for child death arrangements of the relevant details for their representation:

* Cambridgeshire Constabulary
* Cambridgeshire and Peterborough Clinical Commissioning Group
* East of England Ambulance Service NHS Trust
* Cambridge University Hospital NHS Foundation Trust
* Hinchingbrooke NHS Health Care Trust
* Peterborough and Stamford Hospitals NHS Foundation Trust
* Peterborough Children’s Services ([Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/))
* Cambridgeshire County Council – Children and Young People Services ([Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/))
* Coroner for Peterborough
* Coroner for North and East Cambridgeshire
* Coroner for South and West Cambridgeshire

The relevant CDOP member will assume responsibility for ensuring their agency is aware of:

* Awareness raising and publicity.
* Identifying and addressing internal agency training needs and advising the Safeguarding Childrens Partnership with regards to need for interagency training.
* Ensuring this protocol is observed within their organisation.
* Advising the Safeguarding Childrens Partnerships of suggested amendments to the protocol.
* Highlighting and reconciling conflicts within their organisation arising from this protocol.
* Addressing the availability and accessibility of staff.

**Appendix A – Protocol for Deceased Children Presenting to the Emergency Department – Cambridgeshire**

**Guideline**

Deceased children presenting to the Emergency Department

**1   Scope**

Emergency Department (ED)

**2   Purpose**

To clarify management of deceased children in the Emergency Department in line with national and regional recommendations.

**3   Introduction**

Deceased children in the Emergency department fall into two categories: children admitted as an emergency where active resuscitation is still ongoing and children where attempts at active resuscitation are clearly inappropriate or have stopped prior to arrival in ED.

Children who are **actively resuscitated** require investigations and assessment in line with national recommendations and the process is outlined below. This will almost exclusively occur in the paediatric resuscitation area of the ED.

|  |  |  |  |
| --- | --- | --- | --- |
| **Sample** | **Handling** | **Test** | **Purpose** |
| **Blood**Cultures | Microbiology  If insufficient blood, aerobic only | Culture & Sensitivity | Identification of infection – desirable to collect as soon as possible as delays may make interpretation difficult. **It is acceptable to obtain this with a ‘cardiac stab’.** |
| **CSF** | Microbiology –  **CSF samples should not be taken if any suspicion of cranial trauma** | Microscopy, Culture& Sensitivity | Identification of infection  – desirable to collect as soon as possible as delays may make interpretation difficult. One attempt at a lumbar puncture to be attempted and document if this is not successful |
| **Nasopharyngeal aspirate** | Virology | Viral cultures, immunofluorescence and DNA amplification techniques | Identification of viral infections |
| **Nasopharyngeal aspirate or throat swab** | Microbiology | Culture & Sensitivity | Identification of infection |

Children who are **found dead outside hospital** (excluding road traffic collisions or obvious accidental trauma) and where resuscitation either is clearly inappropriate or has stopped prior to arrival will also require assessment and investigations by a paediatrician before transfer to the mortuary. As a matter of principle this will be performed by a senior paediatrician in the ED. At times of high activity this can be challenging, and an alternative location may have to be found. During office hours this could be in the mortuary and – if the child is accompanied by parents (they may choose not to accompany their child) – possibly in the chapel of rest. However, this will need prior discussion with mortuary staff/technicians.

Under no circumstances should these children be assessed (and specimens taken) anywhere outside the Emergency Department or mortuary due to the constraints posed by the Human Tissue Act licence.

**Investigations**

**Appendix B – Protocol for Deceased Children Presenting to the Emergency Department – as agreed by HM Coroner**

**Detailed history and Examination**

**History**

* **Presenting History:** record parents’ accounts of events. Ideally, information should be recorded verbatim- use their own words as far as possible. Detailed history as for any critically ill child.
* **Basic details** of baby/child, the parents, and other family members.
* **A narrative account of the 24 hours** **leading up to the child’s death**. **Unexpected death In children less than 2 yrs. age,** a full description of when and how the baby slept and fed, any activity, who was with the baby at different times, the baby’s health and activity levels, the final sleep and any changes to routine. Where and how the baby was sleeping, clothing, bed coverings, position; any changes in that during the course of the night; if bed sharing, who else was in the bed and their positions relative to the baby; when and by whom the baby was checked during the sleep; description of the last feed and any night time feeds; heating and ventilation.
* Where and how the baby was found, position, coverings, appearance and any unusual features; any action taken after the baby was found.
* **Past medical history**, including pregnancy and delivery, birth weight, post-natal problems, growth and development, normal routine and feeding, any illnesses, immunisations , medications, drug allergies, routine surveillance; Also details of normal routine for the baby, including feeding, sleeping patterns and practices. Check previous OPD/ hospital, A and E, HV and GP visits
* **Family medical history**, including any medical or psychiatric history of the parents and other immediate family members; infectious contacts; any history of respiratory, cardiac, neurological disorders or metabolic disorder in the family and any previous infant or other sudden deaths in the family. The **second twin MUST be examined and investigated appropriately by the Paediatrician**
* **Social history**, family structure and dynamics, housing, use of alcohol, recreational drugs, and tobacco; parents’ occupations; any social services involvement in the past, including any child protection concerns.

**Examination**

* **A detailed examination depends of the clinical presentation**
* **In unexpected deaths**: Consider the following
* Head to toe examination and front to back for bruising/injuries/ visible signs of bleeding/discharge: **use body diagrams to document the injuries (Sheet C of the UHL Standard Child Protection Paperwork)**
* **Examination:** spine, skull, chest, upper limbs, lower limbs, genitalia, anal region
* **Abdomen**: Hepatomegaly
* Signs of dehydration, Rectal temp, Wt./Length/HC, State of nutrition and cleanliness
* Petechiae in distribution of SVC
* **Eye exam:** retinal haemorrhages
* Pre-intubation mouth exam. ENT exam: frenulum/ bleeding/pink fluid from the nose. Frothy fluid, commonly bloodstained, is often present around the nose and or mouth and its presence should be documented.
* Sites of medical intervention: Example: IV lines, IO lines etc needs to be documented
* The presence of any discolouration of the skin, particularly dependent livid. Skin livido and pallor from local pressure (e.g. on the nose in a child who has been face down).

**Samples**

**Initial samples to be taken immediately after sudden unexpected death in infancy/Children (SUDIC)**

* **No samples in NAI cases or suspected NAI cases.**
* [**Consent**](https://safeguardingcambspeterborough.org.uk/glossary/consent/)**:**for post-mortem tissue samples, a fully informed [consent](https://safeguardingcambspeterborough.org.uk/glossary/consent/) must be obtained from the parent or [carer](https://safeguardingcambspeterborough.org.uk/glossary/carer/) with parental responsibility and this must be clearly documented
* **Blood samples taken DURING AND AFTER Resuscitation:**Maintain strict chain of [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) for all the samples taken (chain of [evidence](https://safeguardingcambspeterborough.org.uk/glossary/evidence/) forms-**Appendix 7).** No samples should be sent via the CHUTE.
* Please Fax a copy of this to the coroner, pathologist and the SUDIC paediatrician.
* **No supra-pubic punctures should be attempted for urine samples**.
* Urine/stool stained **nappy** should be preserved and sent for analysis

**“Practice Note – Examination of the body following the unexpected death of a child” (**11 April 2011) Dr Richard Brown – (at that time; Named Doctor for Safeguarding Children, Peterborough).

As soon as is practicable following the cessation of resuscitation, 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 the 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. The purpose of obtaining high quality information at this stage is to understand the cause of 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. A narrative account by the [carer](https://safeguardingcambspeterborough.org.uk/glossary/carer/) of the events leading to death should be documented.

The examination findings, including any post-mortem changes, should be documented on a body chart. Any opinion communicated to [police](https://safeguardingcambspeterborough.org.uk/glossary/police/) or children’s [social care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) regarding such post-mortem changes should be framed within the context of the paediatrician’s experience and training.

**Appendix C – Organisations Contact List**

**Designated Doctor for Deaths in Childhood**

**Cambridgeshire and Peterborough**

Cambridgeshire Community Services

Block 13 Ida Darwin

Fulbourn

CB21 5EE

Tel: 07534980967

**Child Death Review Manager**

**Cambridgeshire and Peterborough**

Jenny Valentine

Cambridgeshire and Peterborough Clinical Commissioning Group

Lockton House

Clarendon Road

Cambridge CB2 8FH

Generic CDOP inbox: [CAPCCG.cdop@nhs.net](mailto:CAPCCG.cdop@nhs.net)  (secure)

**Cambridgeshire and Peterborough Safeguarding Partnership Board**

[http://www.safeguardingcambspeterborough.org.uk](http://www.peterboroughlscb.org.uk/)

Tel: 01733 863744

**Cambridgeshire**[**Social Care**](https://safeguardingcambspeterborough.org.uk/glossary/social-care/)**Contact Centre**

0345 045 0180

**Peterborough**[**Social Care**](https://safeguardingcambspeterborough.org.uk/glossary/social-care/)**Contact Centre**

01733 864180

**Cambridgeshire / Peterborough**[**Social Care**](https://safeguardingcambspeterborough.org.uk/glossary/social-care/)[**Emergency Duty Team**](https://safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/)

01733 234724

**Cambridgeshire Constabulary**

[Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) Headquarters

Hinchingbrooke Park

Huntingdon

PE29 6NP

Tel: 101 or 01480 456111

**BEREAVEMENT ORGANISATIONS**

East Anglia’s Children’s Hospices (EACH)

Bereavement support for children and families in Cambridgeshire and Peterborough

Church Lane

Milton

Cambridge

CB24 6AB

Tel: 01223 815115

Email: [reception@each.org.uk](mailto:reception@each.org.uk)

Web: [www.each.co.uk](http://www.each.co.uk/)

STARS Children’s Bereavement Support Services (Cambridgeshire)

42 High Street

Milton

Cambridge

CB24 6DF

Tel: 01223 863511 Mobile: 07827 743497

Email: [info@talktostars.org.uk](mailto:info@talktostars.org.uk)

Web: www.talktostars.org.uk

**The Child Bereavement Trust**

Aston House, High Street

West Wycombe

High Wycombe

HP14 3AG

Tel:      01494 446648

Email:              [enquiries@childbereavement.org.uk](mailto:enquiries@childbereavement.org.uk)

Website:          [www.childbereavement.org.uk](http://www.childbereavement.org.uk/)

**Child Death Helpline**

Child Death Helpline Administration Centre

York House

37 – 39 Queen Square

London

WC1N 3BH

020 7813 8416

0800 282986

[www.childdeathhelpline.org.uk](http://www.childdeathhelpline.org.uk/)

**The Lullaby Trust (previously The Foundation for the Study of Infant Deaths)**

Bereavement support

[support@lullabytrust.org.uk](mailto:support@lullabytrust.org.uk)

Helpline: 0808 802 6868

Monday – Friday                              10am-5pm

Weekends and public holidays         6pm–10pm

Tel:                  01480 812778

**References**

[[1]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref1) Child Death Review- Statutory and Operational Guidance (England) October 2018

[[2]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref2) Office for National Statistics. Vital Statistics: Population and Health Reference Tables. 2017.  <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables>

[[3]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref3) Working Together 2015 Para 5.12

[[4]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref4) Sn 8(1) Coroners Act 1988

[[a]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref5) A Guide to Investigating Child Deaths ACPO 2014

[[5]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref6) Rule 6(1) a Coroners Rules 1984

[[6]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref7) Royal College of Pathologists Guidelines on Autopsy Practice (2002)

[[7]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref8) [www.cambslscb.org.uk](http://www.cambslscb.org.uk/) and [www.pscb.org.uk](http://www.pscb.org.uk/)

[[8]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/mapmucd/" \l "_ftnref9) Working Together 2015 Para 5.25

**Child exploitation**

**Statement of Intent**

The exploitation of children and young people is the responsibility of the Cambridgeshire and Peterborough Safeguarding Children Partnership Board and Countywide Community Safety Partnership. The multi-agency partnerships are expected to work together across safeguarding and community safety ensuring that young people are supported to safely identify ways to exit and withdraw from exploitation. Young people must also be supported to carefully disclose information, so perpetrators are held accountable and brought to justice. The partnership will ensure that safeguarding responses and procedures are put into place to safeguard, protect, and prevent young people from exploitation. Where possible, agencies should ensure that young people are not criminalised and prosecuted, with such action only used as a last resort.

"Children who are exploited and groomed for criminal purposes are equally as deserving of support. The language of ‘criminal exploitation’ is rarely understood and therefore those affected are not offered the same response. All forms of exploitation should be considered in the same way, with an understanding of grooming and vulnerability. The learning and best practice in place around CSE should be extended to include victims of all forms of exploitation

**Missing People, 2017**

**Cambridgeshire and Peterborough Safeguarding Children Partnership Board Policy Statement**

The Exploitation of Children (CE) is completely unacceptable. Children and young people who are exploited are the victims of child [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/), and their needs require careful assessment and intervention. They are likely to need welfare services and in many cases protection under the Children Act 1989.

It is our collective responsibility to identify those children and young people at risk of exploitation and our joint responsibility to protect them and safeguard them from further risk of [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/). It is also our joint responsibility to prevent children becoming victims of this form of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) and reduce the opportunities that offenders may have to exploit children in the future.

We aim to raise the profile of child exploitation to protect and safeguard children from [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/). We shall achieve this by developing and maintaining effective local responses and through the delivery of an effective multi-agency strategy and delivery plan delivered by key partners through the Child Exploitation Strategic Group. This includes the implementation of timely and effective risk management and the implementation of a comprehensive range of child centred interventions for children who are at risk or are victims of sexual and/or criminal exploitation.

We recognise that child exploitation can have a serious long-term impact on every aspect of a child or young person’s life, health, and education. It can damage the lives of families and carers and can lead to family break ups. Effective interventions delivered by all agencies to assist with these longer-term impacts are also a key area of focus for the Cambridgeshire and Peterborough Safeguarding Children Partnership Board. The partnership will also make a joint commitment to a Contextual Safeguarding Model to ensure that risk is managed, and effective interventions are delivered appropriately.

**Strategy Principles**

Our vision is to reduce child exploitation in Cambridgeshire and Peterborough to keep children safe, so they can lead healthy lives. We commit to taking new, innovative, and evidenced approaches, focusing on [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/) reduction in our communities, preventing victimisation and repeat victimisation, ensuring the lived experiences of the child sits at the centre of our approach. Whilst acknowledging the role of traditional approaches such as Criminal Justice, we will prioritise an approach which seeks to improve the long-term safety leading to positive outcomes for our communities. The partnership recognises there may be a risk associated with this approach, however, accepts this is necessary to deliver resilient, thriving communities.

We will deliver a strong core offer against our statutory partnership responsibilities whilst understanding, where funding is available, how we seek to strengthen this offer.

We will achieve this by –

* Working to prevent children becoming victims and offenders of child exploitation and by challenging the attitudes, behaviours and environments which foster it.
* Ensuring we have an agreed assessment mechanism and threshold to identify, manage and mitigate the risk to vulnerable victims across the county.
* Ensure we work in a way that encourages partnership planning around the child through a contextual safeguarding model and have an agreed core offer for those children at all levels of risk.
* Working to pursue those perpetrators who seek to cause [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/) by exploiting vulnerable children in our communities.
* There will be a designated lead person within each partner organisation with responsibility for implementing the Child Exploitation Strategy where achievable.

**Principles Underpinning the Multi-Agency Response to Child Exploitation in Cambridgeshire and Peterborough**

This strategy is based upon the seven principles set out below, as identified in the ‘See Me, Hear Me Framework’[[1]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-exploitation-strategy-2021-2025/#_ftn1)

**1. The child’s best interests must be the top priority**

The responses by the Cambridgeshire and Peterborough Safeguarding Children Partnership Board to child exploitation seek to take a child centred approach, whilst at the same time recognising that to protect other children and future [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) there is a need to identify, disrupt and prosecute offenders.

Children do not make informed choices to enter or remain in exploitative situations. They do so through coercion, enticement, manipulation, or desperation. Children under 16 years old cannot [consent](https://safeguardingcambspeterborough.org.uk/glossary/consent/) to sexual activity and sexual activity with a child under 13 years is statutory rape.

Sexually exploited children or those at risk, should be treated as victims of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/), not offenders. Prosecution should be focused on those who [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/)children and young people in this way. It is important to remember that these perpetrators may be adults, or they may be the child’s peer or close to their age. The needs of the children within a perpetrator’s family must also be considered.

**2. Participation of children and young people**

‘Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and to have consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say, take their views seriously; and work with them collaboratively when deciding how to support their needs.’[[2]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-exploitation-strategy-2021-2025/#_ftn2) Agencies should always consider the wishes and feelings of the children and young people receiving their services. This is no more or less true for victims or those at risk of child exploitation.

**3. Enduring relationships and support.**

Support should be tailored to meet the needs of the individual, considering their age, ethnicity, beliefs, sexual orientation, disability, language, and maturity. As mentioned above, lasting, trusting relationships with professionals who offer consistent support are crucial to support and protect children and young people and aid their recovery.

As with other areas of child protection, the effective safeguarding of children and young people is best achieved through early help and intervention. Professionals working with young people are well placed to identify risks at an early stage and should ensure they have the knowledge and skills to identify and respond to the vulnerabilities and risk indicators of child exploitation. Information concerning training and guidance and information can be found on the Cambridgeshire and Peterborough Safeguarding Children Partnership Board website.

Professionals should be supported in building relationships with the children and young people they are working with. They should also have access to support for themselves through their line manager and/or the lead for child exploitation within their agency.

**4. Comprehensive problem-profiling**

It is important for all Community Safety Partnerships (CSPs) to establish the prevalence and character of exploitation in their areas. The most effective and accurate profile includes data from a range of agencies, compiled with the oversight of the Missing and Child Exploitation meeting (MACE) and shared across key partners to inform activity concerning child exploitation.

Profiles should contain the following:

1. The incidence of child exploitation: This should include data held by Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/), [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/), health agencies and the voluntary sector (where available) and should be considered for consistency and accuracy. Collection of data may be best facilitated via the Multi-Agency Safeguarding Hub.
2. Information on local trends: The CPSCPB have sought this data from Cambridgeshire Constabulary to strengthen their approach to child exploitation. Information collated by the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) has identified ‘hotspots and those young people considered to be most at risk through their use of the Vulnerability Assessment Tracker (VAT).
3. Prevalence of core risks: This information indicates the probable extent and character of exploitation in the area. This can then be used to determine what type of preventative services are likely to be most effective in reducing the risk of child exploitation.

**5. Effective Information Sharing**

There is in place an effective information-sharing protocol predicated on the [best interests](https://safeguardingcambspeterborough.org.uk/glossary/best-interests/) and safeguarding of children and young people. All relevant agencies and services should be signatories and it should clearly state what information should be shared, by whom and the process for doing this. It can be found here: [Cambridgeshire & Peterborough Multi-Agency Information Sharing](https://www.cambridgeshire.gov.uk/asset-library/imported-assets/CandP%20ISF%20V2.5%20July%202019.pdf)

For more information, professionals should refer to the Department for Education Guidance: ‘Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers’ 2015.

**6. Supervision, support, and training for staff**

Agencies within Cambridgeshire and Peterborough should invest in the development and support of staff including the provision of regular supervision and the opportunities for staff to reflect on practice. Those professionals who offer direct support to exploited children and young people might require further intensive training and must have regular opportunities to reflect on their practice with a skilled line manager or supervisor.

**7. Evaluation and review**

Regular evaluations and reviews of this strategy and the Child Exploitation Delivery Plan must be undertaken to ensure services are progressing activity to reduce the risks posed to young people by child exploitation, and interventions are achieving their intended outcomes. Children and young people from the Cambridgeshire and Peterborough areas should be involved in this process to ensure improvement. Questions against which the strategic response should be evaluated are detailed in the ‘See Me, Hear Me Framework’[[3]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-exploitation-strategy-2021-2025/#_ftn3) under the following headings:

* Voice of the child
* Voice of the professional
* Protecting the child.

**Strategy Aims and Objectives**

**Prevention, Awareness Raising and Training**

Preventing young people from becoming involved in exploitation is crucial if the cycle of [county lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) and gang-related violence is to be broken. The Strategic Group will be responsible for ensuring training is provided across the partnership to enable practitioners to be skilled in identifying exploitation, and knowledgeable about how to respond appropriately to safeguard children and young people.

A programme of training is to be delivered across all schools in Cambridgeshire and Peterborough to allow the education workforce to be fully integrated with work across the areas in respect of tackling and responding to child exploitation. This training should include specific training with staff within Pupil Referral Units, the County Schools and Residential Units because of the vulnerabilities relating to these cohorts of young people.

Training should be delivered to all staff across services working with children and young people. The partnership should ensure that this is delivered in an effective way through identifying training that can be cascaded, as well as appropriate online training modules. The Strategic Group will be responsible for approaching relevant Safeguarding and Community Safety Boards to identify funding to support the rollout of appropriate training for the workforce.

Training for the workforce should include:

* Recognising the signs of child exploitation in children and young people
* Awareness of vulnerable locations across the area
* Association between Child Criminal Exploitation and Child Sexual Exploitation
* How to share intelligence relating to child exploitation concerns
* Procedures relating to safeguarding and protecting children and young people from child exploitation
* Knowledge of thresholds and processes for accessing available support and interventions for those at risk of child exploitation
* Preventative child exploitation interventions for those within Early Help Services
* Intensive safeguarding child exploitation interventions for those within Youth Offending and [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) Services.

The partnership will also be responsible for raising awareness regarding child exploitation amongst children and young people themselves, so we can prevent young people from becoming exploited at the earliest point. Preventative programmes should be delivered in schools, and where possible to parents and professionals. The Strategic Group will be responsible for approaching relevant Safeguarding and Community Safety Boards to identify funding to support the delivery of awareness raising programmes for children and young people.

The training and awareness programme for child exploitation will be supported by the Cambridgeshire and Peterborough Safeguarding Children Partnership Board.

**Governance and Delivery Plan**

This strategy has been agreed by the Cambridgeshire and Peterborough Safeguarding Children Partnership Board. The strategy sets out the priorities and agrees an approach that enhances a county-wide approach to the issue of sexual and criminal exploitation. The rationale being that this will create an environment where sexual and criminal exploitation is effectively prevented, identified and challenged. The Partnership Board have a Child Exploitation Strategic Group where sexual and criminal exploitation work is prioritised and coordinated through the Child Exploitation Delivery Plan. The plan will be refreshed every three months and will be reviewed at the Strategic Group.

A Strategic Child Exploitation Group will include the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/), Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/), Youth Offending Service, Targeted Youth Support Service, Early Help, Cambridgeshire and Peterborough Foundation Trust, Community Safety Partnership representative and the National Probation Service. The partnership is responsible for ensuring that appropriate processes are in place to disrupt and detect those responsible for criminal exploitation and ensure that modern day slavery and trafficking legislation is applied. In addition, the group must also be confident that procedures are in place to identify children and young people at risk and safeguard them from potential [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/).

**Structure of Governance**

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The key objectives of the Child Exploitation Strategic Group and Multi-agency Delivery Plan will be:

* Prevent young people becoming at risk and raise awareness of child exploitation
* Identify and safeguard victims of child exploitation
* Identify and monitor vulnerable locations across the area
* Empower those affected by child exploitation by supporting them to identify strategies to exit and withdraw safely
* Disrupt perpetrators and bring them to justice using modern day slavery and trafficking legislation
* Maximise operational solutions with local, regional, and national partners to disrupt [county lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/), reduce associated criminal exploitation, youth violence and increase youth safety.

**What is Child Sexual Exploitation?**

In March 2015, the Government indicated the intention for the first time to provide a definition of Child Sexual Exploitation (CSE)[[4]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-exploitation-strategy-2021-2025/#_ftn4)  and in February 2017 published advice including definition[[5]](https://safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-exploitation-strategy-2021-2025/#_ftn5) emphasising that CSE is a complex form of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) which can be difficult to identify and assess:

*“Child sexual exploitation is a form of child sexual*[*abuse*](https://safeguardingcambspeterborough.org.uk/glossary/abuse/)*. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.”*

**What is Child Criminal Exploitation?**

Child Criminal Exploitation is common in [county lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) and occurs where an individual, or group, takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person **under the age of 18**. The victim may have been criminally exploited even if the activity **appears consensual.** Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology.

**County Lines**

[County lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) is a major, cross-cutting issue involving drugs, violence, gangs, safeguarding, criminal and sexual exploitation, modern slavery, and missing persons; and the response to tackle it involves the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/), the National Crime Agency, a wide range of Government departments, local government agencies and VCS (Voluntary and Community Sector) organisations. [County lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) activity and the associated violence, drug dealing, and exploitation has a devastating impact on young people, vulnerable adults and local communities.

Individuals or gangs use vulnerable children and adults to transport and sell Class A drugs, primarily from urban areas into market or coastal towns or rural areas, to establish new drug markets or take over existing ones. They often use children to transport and hide weapons and to secure dwellings of vulnerable people in the area, so that they can use them as a base from which to sell drugs.

[County lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) may involve the commission of the offences of ‘slavery, servitude and forced or compulsory labour’ and ‘[human trafficking](https://safeguardingcambspeterborough.org.uk/glossary/human-trafficking/)’ as defined by the Modern Slavery Act 2015. Vulnerable people’s travel may be ‘arranged and facilitated by a person, with the view to them being exploited’, which amounts to [human trafficking](https://safeguardingcambspeterborough.org.uk/glossary/human-trafficking/) according to section 2 of the Modern Slavery Act 2015. Vulnerable people may then be forced to work for the drug dealer, often held in the vulnerable adult’s home against their will and under the force of threat if they do not do as they are told. This meets the definition of ‘slavery, servitude and forced or compulsory labour’ in section 1 of the Modern Slavery Act 2015.

[County lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) is the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines or “deal lines.” It involves child criminal exploitation, as gangs use children and vulnerable people to move drugs and money. Gangs establish a base in the market location, typically by taking over the homes of local vulnerable adults by force or coercion in a practice referred to as ‘cuckooing.’

Some vulnerable persons are forced to carry the drugs in harmful ways that are abusive and could result in their death. For example, ‘plugging’ is commonly used, which is when children or vulnerable adults can be forced by an adult, or another child or vulnerable adult, to insert and carry drugs in their rectum or vagina.

*‘*[*County Lines*](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/)*is a national issue involving the use of mobile phone and train ‘lines’ by groups to extend their drug dealing business into new locations outside of their home areas. This issue affects the majority of forces. A ‘*[*county lines*](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/)*’ enterprise almost always involves exploitation of vulnerable persons; this can involve both children and adults who require safeguarding’ – (National Crime Agency, 2015)*

The national picture on [county lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) continues to develop but there are recorded cases of:

* children as young as 12 years old being exploited or moved by gangs to courier drugs out of their local area; 15-16 years is the most common age range
* both males and females being exploited
* White British children being targeted because gangs perceive they are more likely to evade [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) detection, but a person of any ethnicity or nationality may be exploited
* the use of social media to make initial contact with children and young people
* class A drug users being targeted so that gangs can take over their homes (‘cuckooing’).

While living in a vulnerable adult’s home, far away from their own home, vulnerable people may be required to set up or be part of a new drug market or expand an existing one. This involves vulnerable people putting themselves in extremely dangerous situations with vulnerable adults who are strangers who want to buy Class A drugs from them. Other dealers in the area may also target these vulnerable people to prevent them taking over their ‘patch’. Some people have been stabbed and killed by rival gangs or dealers. Often, the first time that the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) become aware of [county lines](https://safeguardingcambspeterborough.org.uk/glossary/county-lines/) activity in their area is because of a significant increase in knife crime and youth violence.

It needs to be understood and acknowledged by all professionals that young people are subjected to significant pressure and coerced into criminal activity and, as such, feel they have no choice other than to follow the instructions of those who are exploiting and therefore subjecting them to [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/).

**Missing Children and Young People**

This section should be read in conjunction with the CPSCPB Protocol on Missing Children and Young People: [Cambridgeshire and Peterborough Children Missing from Home or Care Protocol](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/missing-from-home-or-care/)

There are clear links between children and young people who go missing from home or care settings and child exploitation. Missing episodes are a high-risk indicator of child exploitation.

Assessing situations, such as missing children, goes beyond the simplicity of the actual event and needs a much more sophisticated approach. Agencies need to be mindful of the fact that the focus on the number of occasions where a child goes missing, is not as important as why they go missing and the increased risks they face when they do. Any kind of assessment must take this view and must look at any factors which may ‘push’ or ‘pull’ a child or young person into sexual exploitation. ‘Push’ factors are exactly what you would expect – they are things that push a child away from home. They include not feeling accepted in the environment where children should be safe and happy. Family breakdown and arguments can generate ‘pushing away’, as can [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/), drug and alcohol misuse by family members, and new step-families moving in.

**Agency and Professional Responsibilities:**

**Responsibility of all agencies**

No one agency can address the complex elements of child exploitation on its own, largely because a child’s and family’s needs cannot always be met by a single agency. Effective interventions, whether early help, child in need or child protection, depend on professionals developing working relationships which are sympathetic to each other’s legal responsibilities, agency’s purpose and procedures, respective roles and agencies capacities.

All agencies represented on the Cambridgeshire and Peterborough Safeguarding Children Partnership Board have a responsibility to contribute to the safeguarding of children in Peterborough and Cambridgeshire.

**Responsibility of Health**

Health is a universal service that is accessed by individuals from all the communities in Cambridgeshire and Peterborough. Health professionals are involved with children and families throughout their lives and consequently they get to know families in more detail than other statutory agencies. Health professionals, particularly sexual health workers, school nurses and specialist paediatric staff, spend time with young people either in people’s homes or other establishments (schools/hospitals/clinics) and are very well-placed to identify cases of child exploitation. It is important that health professionals are alert to the signs of sexual exploitation in young people and attend the numerous safeguarding training opportunities that are available to them. The nature and impact of child sexual exploitation is cumulative and corrosive, so it is essential that all health professionals maintain accurate, detailed and contemporaneous records that help to form a “picture” of the exploitation. When a practitioner identifies concerns regarding exploitation in a young person’s life, they should speak to a member of the Health Safeguarding Children team to determine what the next steps to take are.

**Responsibility of Children’s Services**

Children’s Services are responsible for co-ordinating statutory assessments of children’s needs which include the parent’s capacity to meet those needs. The assessment may result in the provision of services designed to address the identified needs of the child through a child in need plan. Where a child is assessed as having suffered, or being at risk of, significant [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/) as a result of Exploitation Children’s services will follow a Contextual Safeguarding process to ensure that extra familial risks are considered on a multi-agency basis. This may result in the child becoming subject of a Contextual Safeguarding Conference  Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) has the statutory responsibility for Contextual Safeguarding, but it will work with other agencies to develop, implement, and monitor a plan (Child in Need or Contextual Safeguarding) to help the child and their family to manage extra familial risks. At times young people may not wish to engage with Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/), however a Contextual Safeguarding model and approach can still be accessed with an alternative lead professional who will be supported.

**Responsibility of Police**

The [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) have a duty of care to protect all members of the community and to bring offenders to justice. The welfare of children is a priority for the service, and all officers are responsible for identifying and referring children who are at risk or in need. Any Officer can utilise emergency powers to ensure immediate protection of children believed to be at immediate risk of suffering significant [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/) (this is a very draconian step and should only be utilised in exceptional cases). The [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) regularly enter people’s homes or target known crime hotspots and are therefore well placed to identify issues that might indicate child exploitation. In these circumstances the [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) should liaise with Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) or the Early Help Team. It is imperative that [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/)Officers attend safeguarding training so that they are aware of the signs of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) and exploitation and know the pathway to follow if they have concerns.

**Responsibility of Education**

All schools play a significant role in the prevention and identification of all forms of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/). Schools are a universal service that often provide a safe environment for children and young people. Due to the amount of time that school staff spend with children (and their families) they often know the child and their circumstances better than other agencies.

Schools and settings therefore play a crucial role in identifying behaviours that may be indicative of child exploitation. Concern that a child or young person may be involved in sexual or criminal exploitation, or is at risk of being drawn into it, should always initiate action to ensure the child’s safety and welfare.

All education settings should have a policy which sets out how they will address child exploitation. This may be part of the full safeguarding policy or a standalone document. The training for Designated Safeguarding Leads includes additional information and guidance on child exploitation including the use of the Risk Assessment and Management Tool. The Safeguarding Governor should also be aware of their responsibilities for child exploitation.

All adults in schools and settings should be always vigilant and aware of the possible indicators of child exploitation to be able to identify those at risk of being exploited.

There should be provision within the curriculum in all schools and settings for children and young people, from an early age, to understand the meaning of healthy, positive relationships and learn about how to keep themselves and others safe.

**Responsibility of Housing**

Housing providers and services may have essential information about families or locations identifying cases of exploitation or contributing information to assessments. Staff have an important part to play in reporting concerns where they believe that a child may need support through early help, or in need of statutory intervention.

It is important that housing professionals attend safeguarding training so that they are aware of the signs of [abuse](https://safeguardingcambspeterborough.org.uk/glossary/abuse/) and exploitation and know the pathway to follow if they have concerns.

**Responsibility of Probation Services**

In discharging its statutory responsibilities, the National Probation Service (NPS), through its work with offenders and their families, may become aware of children who are at risk of child exploitation. All Probation staff have a responsibility to be aware of the signs of potential child exploitation and to refer appropriate cases to Early Help or Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/).

In line with its statutory responsibilities, NPS staff will provide advice to the courts regarding the sentencing of offenders convicted on child exploitation related offences and work closely with prison staff to address their offending behaviour during their sentence. NPS will also work closely with community partner agencies (such as [Police](https://safeguardingcambspeterborough.org.uk/glossary/police/) and [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/)) when supervising offenders on licence after their release from prison to protect the public and reduce the potential for further [harm](https://safeguardingcambspeterborough.org.uk/glossary/harm/).

NPS staff will work in collaboration with other agencies at strategic and operational level in developing effective partnership work in dealing with child exploitation. This will include contributing to assessments on individual cases and following all relevant child protection policies, procedures, and protocols.

**Responsibility of Youth Offending Service**

The Youth Offending Service aims to prevent offending and re-offending of children aged 10-17. All YOS staff have a responsibility to be alert to safeguarding issues in their work with children and their families and must ensure that all young people are assessed to identify risk of Exploitation. Exploitation Risk Assessment Management Tools should be completed where appropriate and appropriate concerns should be raised with line managers and where appropriate referred to Children’s [Social Care](https://safeguardingcambspeterborough.org.uk/glossary/social-care/) and specialist exploitation teams.

**Responsibility of the Voluntary and Community Sector**

The VCS often undertake a range of programmes with young people experiencing complex issues, including those affected by exploitation. The VCS are therefore well-placed to identify early concerns that relate to exploitation.

**Responsibility to share information**

Information sharing is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection.

It is important that practitioners can share information appropriately as part of their day-to-day practice and do so confidently.

It is important to remember there can be significant consequences to not sharing information as there can be to sharing information. You must use your professional judgement to decide whether to share or not, and what information is appropriate to share.

Data protection law reinforces common sense rules of information handling. It is there to ensure personal information is managed in a sensible way.

It helps agencies and organisations to strike a balance between the many benefits of public organisations sharing information and maintaining and strengthening safeguards and privacy of the individual.

It also helps agencies and organisations to balance the need to preserve a trusted relationship between practitioner and child and their family with the need to share information to benefit and improve the life chances of the child.

**Performance and Quality Assurance Framework**

The Cambridgeshire and Peterborough Safeguarding Children Partnership Board are responsible for scrutinising multi-agency performance data. To assess the impact of this strategy the Strategic Child Exploitation Group will regularly monitor the following multi-agency quality assurance information:

* What children, young people and their families tell us
* Thematic case audits (both single and multi-agency)
* In addition, the following outcome indicators will be used to provide the Strategic Child Exploitation Group with insight into the effectiveness of the strategy
* Contacts received by the MASH specifically associated with child exploitation, including age, gender, ethnicity and referring agency.
* Data concerning children who go missing from home and care, including age, gender, frequency of episodes and length of episodes.
* Significant risk child exploitation or missing c

**All Children Presenting Alone or with Adults who are Not Their Parents**

**Introduction**

[Evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) shows that unaccompanied migrant children or those accompanied by someone who is not their parent are particularly vulnerable. Immigration legislation impacts significantly on work to safeguard and promote the welfare of children and young people from abroad.

It is important to note that regulations and legislation in this area of work are complex and subject to constant change through legal challenge. This guidance, therefore, intends to provide an overview of the additional issues faced by families and/or children set within the framework of immigration law. All practitioners need to be aware of this context in their contact with such families and/or children. Legal advice about individual cases may be required.

Additional issues are likely to arise in relation to this cohort of children, whether or not they are found to be, or suspected of being, victims of trafficking or modern slavery. Additional considerations in all cases are likely to include issues such as immigration status, the need for interpreters and specialist legal advice. Some of these children may have been persecuted and have witnessed or been subject to horrific acts of violence. Assessing the needs of these children is only possible if their legal status, background experiences and culture are understood, including the culture shock of arrival in this country.

Unaccompanied, internally displaced children may come to the UK seeking asylum or may be here to attend school or join their family. An unaccompanied child may be the subject of a Private Fostering arrangement, and subsequently exploited or abandoned when the arrangement fails.

Some children may say they are unaccompanied when claiming asylum – a trafficker may have told the child that in doing so they will be granted permission to stay in the UK and be entitled to claim welfare benefits.

A significant number of children who are referred to local authority care as trafficked children or unaccompanied asylum seeking children (UASC), often then go missing and many go missing within one week. It is thought that they are then trafficked internally, within the UK, or out of the UK to other European countries.

Whenever an unaccompanied child presents in a local authority area, all agencies dealing with the child should be alert to the possibility that the child may have been a victim of modern slavery, including the possibility that the child has been trafficked, and ensure that all relevant information about the child’s circumstances is communicated to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/). Information should be shared with [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) where appropriate and where possible, but information can be shared without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) if the professional judgement is that there is good reason to do so, such as where their safety may be at risk.

If there are concerns that a child is a victim of trafficking, the practitioners will need to inform the National Referral Mechanism, which is a framework for identifying victims of [human trafficking](https://www.safeguardingcambspeterborough.org.uk/glossary/human-trafficking/) or modern slavery and ensuring that they receive the appropriate support. The child’s details should be provided using the forms available on the NCA [**National Referral Mechanism: Digital Referral System: Report Modern Slavery**](https://www.modernslavery.gov.uk/start).

In England and Wales, if someone is found not to be a victim of trafficking, the Competent Authority must go on to consider whether they are the victim of another form of modern slavery, which includes slavery, servitude and forced or compulsory labour.

This chapter should be read in conjunction with the following government guidance:

[**Care of Unaccompanied Migrant Children and Child Victims of Modern Slavery: Statutory Guidance for Local Authorities, November 2017**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656429/UASC_Statutory_Guidance_2017.pdf) – This guidance sets out the steps local authorities should take to plan for the provision of support for looked after children who are unaccompanied asylum seeking children, unaccompanied migrant children or child victims of modern slavery including trafficking. Elements of this guidance will also be relevant for the care of looked after UK nationals who may also be child victims of modern slavery.

[**Safeguarding Children who May Have Been Trafficked (Home Office, 2011)**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/177033/DFE-00084-2011.pdf) – non-statutory government good practice guidance provides the detailed guidance on steps that local authorities should take, in partnership with other agencies, to identify and protect child victims of modern slavery, including trafficking, before they become looked after.

This document should also be read alongside the [**East of England Unaccompanied Asylum Seeking Children (UASC) Safeguarding Protocol, agreed by UK Visas and Immigration; Families, Communities & Young People Regional group; and Eastern Region Police Forces**](https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2016/06/East-of-England-Unaccompanied-Asylum-Seeking-Children-UASC-Oct-2015.pdf)

**Issues and Challenges**

The first contact with the child and carers is crucial to the engagement with the family and the promotion of trust which underpins the future support, advice and services.

Such children should be assessed as a matter of urgency as they may be very geographically mobile and their vulnerabilities may be greater. All agencies should enable the child to be quickly linked into universal services, which can begin to address educational and health needs.

The assessment has to address not only the barriers which arise from cultural, linguistic and religious differences, but also the particular sensitivities which come from the experiences of many such children and families.

Particular sensitivities which may be present include:

* Concerns around immigration status;
* Fears of repatriation;
* Anxiety raised by yet another professional asking similar question to ones previously asked;
* Lack of understanding of the separate role of Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), and that it is not an extension of the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/);
* Lack of understanding of why an assessment needs to be carried out;
* Previous experience of being asked questions under threat or torture, or seeing that happen to someone else;
* Past trauma – past regime/experiences can impact upon the child’s mental and physical health. This experience can make concerns from the Authorities about minor injury or poor living conditions seem trivial and this mismatch may add to the fear and uncertainty;
* The journey itself as well as the previous living situation may have been the source of trauma;
* The shock of arrival – the alien culture, system and language can cause shock and uncertainty, and can affect mood, behaviour and presentation;
* The child may have also been subject to frequent changes of address or location within the UK and may be living with the fear of sudden further unexplained moves.

Agencies should ensure that the interpreter shares a common language with the child, is professionally trained and has been screened through a DBS check. It is vital that the services of an interpreter are employed in the child’s first language and that care is taken to ensure that the interpreter knows the correct dialect.

**Age Assessments**

The assessment of age is a complex task, which often relies on professional judgement and discretion. Many societies do not place a high level of importance upon age and it may also be calculated in different ways. Some young people may genuinely not know their age and this can be misread as lack of co-operation. Levels of competence in some areas or tasks may exceed or fall short of our expectations of a child of the same age in this country.

Age assessments should only be carried out where there is significant reason to doubt that the claimant is a child. Age assessments should not be a routine part of a local authority’s assessment of unaccompanied or trafficked children. [**Care of Unaccompanied Migrant Children and Child Victims of Modern Slavery – Statutory Guidance for Local Authorities (November 2017)**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656429/UASC_Statutory_Guidance_2017.pdf) provides that where the age of a person is uncertain and there are reasonable grounds to believe that they are under 18, they will be treated as a child in order to receive immediate access to assistance, support and protection in accordance with Section 51 of the Modern Slavery Act 2015. An age assessment should only be carried out if it is appropriate to do so, and should not cause a delay in referring into the NRM. Where age assessments are conducted, they must be compliant with case law of Merton and subsequent judgements.

As the issue of age assessment in social work with asylum seeking young people remains controversial, the ADCS (Association of Directors of Children’s Services) Asylum Task Force has worked with the Home Office to provide jointly agreed [**Age Assessment Guidance and Information Sharing Guidance for UASC**](http://adcs.org.uk/safeguarding/article/age-assessment-information-sharing-for-unaccompanied-asylum-seeking-childre).

The advice of a paediatrician with experience in considering age may be needed to assist in this, in the context of a holistic assessment. However, the High Court has ruled that, unless a paediatrician’s report can add something specific to an assessment of age undertaken by an experienced social worker, it will not be necessary.

**Immigration Issues**

The immigration status of a child and his/her family has implications for the statutory responsibilities towards the family. It governs what help, if any, can be provided to the family and how help can be offered to the child.

All children, irrespective of their immigration status, are entitled to protection under the law. Local authorities need to ensure that child victims receive legal advice and support.

Where families are subject to immigration legislation which precludes support to the family, many will disappear into the community and wait until benefits can be awarded to them. During this interim period the children may suffer particular hardship – e.g. live in overcrowded and unsuitable conditions with no access to health or educational services. They are particularly vulnerable to exploitation because of their circumstances.

Children who disappear, where there are concerns about the child’s welfare, should be considered to be missing and [**Cambridgeshire and Peterborough Children Missing from Home or Care Procedure**](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/missing-from-home-or-care/) should be followed.

It may be appropriate for unaccompanied children to be informed of the availability of the [**Assisted Voluntary Return Scheme**](https://www.gov.uk/return-home-voluntarily).

**Asylum Process – Possible Outcomes**

There are four main possible outcomes of the asylum process for an unaccompanied child, which will determine what the long term solution might be. These are outlined below including the impact they may have on care and pathway planning:

* **Granted refugee status** (i.e. granted asylum), with limited [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/) for five years, after which time they can normally apply for settlement (i.e. indefinite [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/)).
* **Refused asylum but granted humanitarian protection**, with limited [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/) for five years, after which time they can normally apply for settlement (i.e. indefinite [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/)). This is most commonly granted where the person is at risk of a form of ‘[ill treatment](https://www.safeguardingcambspeterborough.org.uk/glossary/ill-treatment/)’ in their country of origin but which does not meet the criteria of the Refugee Convention.  
  As it is very likely that those granted refugee status or humanitarian protection will qualify for indefinite [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/), their care and pathway planning should primarily focus on their long-term future in the UK, in the same way as for any other care leaver.
* **Refused asylum but granted Unaccompanied Asylum Seeking Child (UASC) Leave**. This is normally for 30 months or until the age of 17½, whichever is the shorter period. This form of leave is granted to unaccompanied children where they do not qualify for refugee status or humanitarian protection, but where the Home Office cannot return them to their home country because it is not satisfied that safe and adequate reception arrangements are in place in that country. It is a form of temporary [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/) and is not a route to settlement. This decision is a refusal of the child’s asylum claim and will attract a right of appeal. The child should be assisted to obtain legal advice on appealing against such a refusal. Before the child’s UASC Leave expires, they can submit an application for further [leave to remain](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/) and/or a fresh claim for asylum, which will be considered. It is essential that they are assisted to access legal advice and make any such further application or claim before their UASC Leave expires.  
  In such cases, care and pathway planning should therefore consider the possibility that the child may have to return to their home country once their UASC Leave expires or that they may become legally resident in the UK long-term (if a subsequent application or appeal is successful). Planning should also cover the possibility that they reach the age of 18 with an outstanding application or appeal and are entitled to remain in the UK until its outcome is known.
* **Refused asylum and granted no**[**leave to remain**](https://www.safeguardingcambspeterborough.org.uk/glossary/leave-to-remain/). In this case the unaccompanied child is expected to return to their home country and their care plan should address the relevant actions and the support required. The Home Office will not return an unaccompanied child to their home country unless it is satisfied that safe and adequate reception arrangements are in place in that country. Any appeal or further application should be submitted where appropriate by the child’s legal adviser.

Although these are the four main types of outcomes for an unaccompanied child, there may be others. For example, a child may be granted discretionary leave depending on whether they meet other criteria such as needing to stay in the UK to help [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) with their enquires after being conclusively identified as a victim of trafficking. Other examples include: leave as a stateless person; limited or discretionary leave for compassionate reasons; and limited leave on the basis of family or private life.

**Independent Family Returns Panel**

The Secretary of State must consult the Independent Family Returns Panel in each family returns case, on how best to safeguard and promote the welfare of the children of the family, and in each case where the Secretary of State proposes to detain a family in pre-departure accommodation, on the suitability of so doing, having particular regard to the need to safeguard and promote the welfare of the children of the family.

A family returns case is a case where a child who is living in the United Kingdom is to be removed from or required to leave the United Kingdom, together with their parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/).

Pre-departure accommodation is a secure facility designed to be used as a last resort where families fail to co-operate with other options to leave the UK, such as the offer of assisted voluntary return.

The Panel may request information in order that any return plan for a particular family has taken into account any information held by other agencies that relates to safeguarding, welfare or child protection. In particular a social worker or manager from Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) may be invited to contribute to the Panel.

**Referring a Potential Victim of Modern Slavery to the National Referral Mechanism (NRM)**

A local authority (as a ‘first responder’) identifying a potential victim of modern slavery must refer them to the National Referral Mechanism (NRM) for consideration by the Single Competent Authority (SCA). Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) departments are able to make a referral into the NRM, as they may be entitled to further support. Victims can be of any nationality, and may include British national children, such as those trafficked for child sexual exploitation or those trafficked as drug carriers internally in the UK. The NRM does not supersede child protection procedures, so existing safeguarding processes should still be followed in tandem with the notifications to the NRM. See also [**National Referral Mechanism: Guidance for Child First Responders**](https://www.gov.uk/government/publications/national-referral-mechanism-guidance-for-child-first-responders).

There is no minimum requirement for justifying a referral into the NRM and [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) is not required for children. Communicate honestly with the child about your concerns and reasons for referring them into the NRM.

To complete and see where to send the forms, and the associated guidance, visit [**Digital Referral System: Report Modern Slavery**](https://www.modernslavery.gov.uk/start).

The Duty to Notify – Local authorities have a duty to notify the Home Office about any potential victims of Modern Slavery. It is intended to gather better data about modern slavery. This requirement can be satisfied by completing the National Referral Mechanism Digital Form.

**Protection and Action to be Taken**

Whenever any professional comes across a child who they believe has recently moved into this country the following basic information should be sought:

* Confirmation of the child’s identity and immigration status;
* Confirmation of the [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s relationship with the child and immigration status;
* Confirmation of the child’s health and education arrangements in this country;
* Confirmation of the child’s health and education arrangements in the country of origin and any other country that the child has travelled through.

This should be done in a way which is as unthreatening to the child and [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) as possible.

When an unaccompanied child or child accompanied by someone who does not have Parental Responsibility comes to the attention of any practitioner, a referral should be made to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) in accordance with the **Making a Referral Procedure**. An Assessment will be undertaken in order to determine whether they are a Child in Need of services, including the need for protection.

Whether they are unaccompanied or accompanied by someone who is not their parent they should be assumed to be a Child in Need unless assessment indicates that this is not the case. The assessment of need should include a separate discussion with the child in a setting where, as far as possible, they feel able to talk freely. This, in itself, may be a complex process where the assessor may not be able to speak the same language as the child.

Many unaccompanied and/or trafficked children are at risk of going missing from care, often within the first 72 hours, whilst others may be at risk of repeated missing episodes due to ongoing exploitation.

**Assessment**

The Assessment will be conducted in accordance with the [**Assessment Procedure**](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-and-family-assessment/). The following additional issues will also need to be taken into consideration.

Assessing the needs of these children is only possible if their legal status, background experiences and culture are understood, including the culture shock of arrival in this country.

This is a highly complex area of work and professionals will need to have available to them a solid understanding of the asylum process or colleagues or other professionals with such expertise.

Seeking information from abroad should be a routine part of assessing the situation of an unaccompanied child. Practitioners from all key agencies – Health, Education, Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) – should all be prepared to request information from their equivalent agencies in the country or countries in which a child has lived, in order to gain as full as possible a picture of the child’s preceding circumstances.

The child should be offered an Independent Visitor and, if they decline, their reasons should be recorded. Any Independent Visitor appointed should have appropriate training and demonstrate an understanding of the needs faced by unaccompanied or trafficked children.

The Assessment should take account of any particular psychological or emotional impact of experiences as an unaccompanied or trafficked child, and any consequent need for psychological or mental health support to help the child deal with them.

Unaccompanied migrant children and child victims of modern slavery will need access to specialist legal advice and support. This will be in relation to immigration and asylum applications and decisions and any associated legal proceedings. If they have been a victim of modern slavery, it may also be in relation to criminal proceedings or compensation claims. The assessment should note that specialist legal support is required and how it will be provided.

Planning for the child should include planning for a variety of possible outcomes regarding the child’s immigration status – see [**Asylum Process – Possible Outcomes**](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/children-from-abroad-including-victims-of-modern-slavery-trafficking-and-exploitation/#elementor-toc__heading-anchor-5).

**Part 2 – Child Victims of Trafficking and/or Modern Slavery**

**Definitions**

‘Modern slavery’ is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal and financial gain. It encompasses [human trafficking](https://www.safeguardingcambspeterborough.org.uk/glossary/human-trafficking/), slavery, servitude and forced labour.

The Modern Slavery Act 2015 provides better protection for victims and increases the sentences for committing these offences.

Grooming methods are often used to gain the trust of a child and their parents, e.g. the promise of a better life or education, which results in a life of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), servitude and inhumane treatment.

‘Trafficking of persons’ means the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) of a person having control over another person, for the purpose of exploitation.

‘Exploitation’ for modern slavery purposes is defined, as a minimum, to include: sexual exploitation, forced labour, domestic servitude and organ trafficking.

Trafficked victims are coerced or deceived by the person arranging their relocation, and are often subject to physical, sexual and mental [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). The trafficked child or person is denied their human rights and is forced into exploitation by the trafficker or person into whose control they are delivered.

Children are not considered able to give ‘informed [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/)’ to their own exploitation (including criminal exploitation), so it is not necessary to consider the means used for the exploitation – whether they were forced, coerced or deceived, i.e. a child’s [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to being trafficked is irrelevant and it is not necessary to prove coercion or any other inducement.

**Types of Exploitation**

Boys and girls of all ages are affected and can be trafficked into, within (‘internal trafficking’), and out of the UK for many reasons and all forms of exploitation.

Victims may be sexually exploited and forced into sex work. Victims have been found in brothels, saunas and lap dancing clubs. Persons subject to forced labour have been found working with little or no pay in farms, factories, nail bars, car washes, hotels and restaurants. Domestic servitude involves victims who work in a household where they are subject to long working hours with little or no pay, often in very poor working conditions. Sometimes forced marriage can lead to domestic servitude. Criminal exploitation can involve young people being forced to work in cannabis cultivation, [county lines](https://www.safeguardingcambspeterborough.org.uk/glossary/county-lines/)exploitation, begging and pick-pocketing. Other types of exploitation include debt bondage (being forced to work to pay off debts that realistically they will never be able to), organ harvesting, financial fraud (including benefit fraud), and illegal adoption. For further information see [**Typology of 17 Types of Modern Slavery Offences in the UK**](https://www.gov.uk/government/publications/a-typology-of-modern-slavery-offences-in-the-uk).

Victims often face more than one type of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and slavery, for example they may be sold to another trafficker and then forced into another form of exploitation.

Children and young people may be exploited by parents, carers or family members. Often the child or young person will not realise that family members are involved in the exploitation.

The Modern Slavery Act 2015 (applicable mostly in England and Wales[1]) provides two civil prevention orders – the Slavery and Trafficking Prevention Orders (STPO) and Slavery and Trafficking Risk Order (STRO), and provision for child trafficking advocates.

[1] Some provisions also concern Northern Ireland and Scotland. Also see the [Human Trafficking](https://www.safeguardingcambspeterborough.org.uk/glossary/human-trafficking/) and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015 and the [Human Trafficking](https://www.safeguardingcambspeterborough.org.uk/glossary/human-trafficking/) and Exploitation (Scotland) Act 2015.

**Indicators**

Identification of potential child victims of modern slavery/trafficking may be difficult as they might not show obvious signs of distress or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Some children are unaware that they have been trafficked, while others may actively participate in hiding that they have been trafficked. Even when a child understands what has happened, they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults. It is important that these children are protected too. Children do not have the legal capacity to ‘[consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/)’ to their trafficking or their exploitation.

Signs that a child has been trafficked may not be obvious, or children may show signs of multiple forms of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect. Spotting the potential signs of child slavery/trafficking in referrals and children you work with can include:

* A reluctance to seek help – victims may be wary of the authorities for many reasons such as not knowing who to trust or a fear of deportation or concern regarding their immigration status and may avoid giving details of accommodation or personal details;
* The child may seem like a willing participant in their exploitation, e.g. involvement in lucrative criminal activity – however this does not mean they have benefitted from the proceeds;
* Discrepancies in the information victims have provided due to traffickers forcing them to provide incorrect stories;
* An unwillingness to disclose details of their experience due to being in a situation of dependency;
* Brought or moved from another country;
* An unrelated or new child discovered at an address;
* Unsatisfactory living conditions – may be living in dirty, cramped or overcrowded accommodation;
* Missing – from care, home or school – including a pattern of registration and de-registration from different schools;
* Children may be found in brothels and saunas;
* Spending a lot of time doing household chores;
* May be working in catering, nail bars, caring for children and cleaning;
* Rarely leaving their home, with no freedom of movement and no time for playing;
* Orphaned or living apart from their family, often in unregulated private foster care;
* Limited English or knowledge of their local area in which they live;
* False documentation, no passport or identification documents;
* Few or no personal effects – few personal possessions and tend to wear the same clothing;
* No [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of parental permission for the child to travel to the UK or stay with the adult;
* Little or no [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of any pre-existing relationship with the adult or even an absence of any knowledge of the accompanying adult;
* Significantly older partner;
* Underage marriage.

**Physical Appearance** – Victims may show signs of physical or psychological [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), look malnourished or unkempt, or appear withdrawn.

**Physical Illnesses** – Including work-related injuries through poor health and safety measures, or injuries apparently as a result of assault or controlling measures. There may be physical indications of working (e.g. overly tired in school or indications of manual labour).

**Sexual Health Indicators** – Sexually transmitted infections, or pregnancy; injuries of a sexual nature and /or gynaecological symptoms.

**Psychological Indicators** – Suffering from post traumatic stress disorder which may include symptoms of hostility, aggression and difficulty with recalling episodes and concentrating. Depression/self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and/or suicidal feelings; an attitude of self blame, shame and extensive loss of control; drug and/or alcohol use.

**Protection and Action to be Taken**

Modern slavery and trafficking are child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), and any potential victim of child trafficking or slavery, servitude, or forced or compulsory labour should immediately be referred to Children’s Services in the area, as they may be suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) – see **Making a Referral Procedure**.

In addition to the usual actions to be taken, additional considerations will apply if the child is suspected of being a victim of trafficking and/or modern slavery. Once a potential victim has been identified, practitioners should inform them of their right to protection, support, and assistance in any criminal proceedings against offenders. Practitioners should arrange access to specialist legal advice and support. Trafficked children may apply to UK Visas and Immigration for asylum or humanitarian protection. This is because they often face a high level of risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) if they are forced to return to their country of origin.

If the child or anyone connected to them is in immediate danger the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) should be contacted as normal.

Practitioners should meet any urgent health needs and arrange emergency medical treatment if appropriate.

Practitioners must arrange safe accommodation for the potential victim.

**Assessment**

Where a child is a victim or potential victim of Modern Slavery/Trafficking, the Assessment should be carried out immediately as the opportunity to intervene is very narrow. Many trafficked children go missing from care, often within the first 72 hours. There should be a clear understanding between the local authority and the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) of roles in planning for the protection and responding if a child goes missing.

During the Assessment, the lead social worker should establish the child’s background history including a new or recent photograph, passport and visa details, Home Office papers and proof and details of the guardian or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/).

Where the outcome of the assessment is that the child becomes looked after, the social worker and carers must consider the child’s vulnerability to the continuing influence/control of the traffickers and how they may seek to contact them for instance by mobile phone or the internet. Planning and actions to support the child must minimise the risk of the traffickers being able to re-involve a child in exploitative activities:

* The location of the child must not be divulged to any enquirers until they have been interviewed by a social worker and their identity and relationship/connection with the child established, with the help of [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and immigration services, if required;
* Foster carers/residential workers must be vigilant about anything unusual e.g. waiting cars outside the premises and telephone enquiries.

The social worker must immediately pass to the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) any information on the child (concerning risks to her/his safety or any other aspect of the law pertaining either to child protection or immigration or other matters) which emerges during the placement. The social worker must try to make contact with the child’s parents in the country of origin (immigration services may be able to help), to find out the plans they have made for their child and to seek their views. The social worker must take steps to verify the relationship between the child and those thought to be her/his parent/s.

Anyone approaching the local authority and claiming to be a potential [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/), friend, member of the family etc, of the child, should be investigated by the social worker, the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and immigration service. If the supervising manager is satisfied that all agencies have completed satisfactory identification checks and risk assessments, the child may transfer to their care.

The child should be offered an Independent Visitor and, if they decline, their reasons should be recorded. Any Independent Visitor appointed should have appropriate training and demonstrate an understanding of the needs faced by unaccompanied or trafficked children.

The Assessment should take account of any particular psychological or emotional impact of experiences as an unaccompanied or trafficked child, and any consequent need for psychological or mental health support to help the child deal with them.

Practitioners must always ensure that a victim-centred approach to tackling all types of trafficking and modern slavery is taken. This can be achieved by the following:

* Dealing with the child sensitively to avoid them being alarmed or shamed – building trust, as victims commonly feel fear towards the authorities;
* Keeping in mind the child’s:
  + Added vulnerability;
  + Developmental stage;
  + Possible grooming by the perpetrator.

A child’s credibility can be challenged if the child is subject to immigration control on the basis of their disclosure being made in instalments. It is important that practitioners make careful notes about what is disclosed, as a child may have difficulty recalling what they’ve experienced as a result of trauma. This will support the child and help others understand the process of disclosure.

When questioning a potential victim, initially observe non verbal communication and body language between the victim and their perpetrator.

It is important to consider the potential victim’s safety and that of their loved ones. Confidentiality and careful handling of personal information is imperative to ensure the child’s safety. Practitioners must not disclose to anyone not directly involved in the case, any details that may compromise their safety.

For further advice and support the [**Child Trafficking Advice Centre (CTAC)**](https://learning.nspcc.org.uk/services/child-trafficking-advice) provides free guidance to professionals concerned that a child or young person is a victim of modern slavery.

**Communication difficulties**

**1. Introduction**

All agencies need to ensure they are able to communicate fully with parents and children when they have concerns about child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect and ensure that family members and professionals fully understand the exchanges that take place.

Consideration should be given to the use of intermediaries during interviews, assessments and/or [advocacy](https://www.safeguardingcambspeterborough.org.uk/glossary/advocacy/), when appropriate.

**2. Recognition of Communication Difficulties**

In taking a referral social workers must establish the communication needs of the child, parents and other significant family members. Relevant specialists may need to be consulted e.g. a language therapist, teacher of hearing impaired children, paediatrician etc.

The use of accredited interpreters, signers or others with special communication skills must be considered whenever undertaking enquiries involving children and/or family:

* For whom English is not the first language (even if reasonably fluent in English, the option of an interpreter must be available when dealing with sensitive issues);
* With a hearing or visual impairment;
* Whose disability impairs speech;
* With learning difficulties;
* With a specific language or communication disorder;
* With severe emotional and behavioural difficulties;
* Whose primary form of communication is not speech.

Family, friends or involved professionals should not be used as interpreters within the interviews although can be used to arrange appointments and establish communication needs. Children should never be used as interpreters.

For children and/or parents requiring interpreters, it is vital to establish their dialect, pertaining to their country of origin, as it might have significant outcomes for the translation. It should also be noted that cultural issues between the interpreter and victim / witness might have a bearing on the translation or disclosure. When planning using an interpreter consideration should always be given to gender and religious and cultural beliefs respected.

**3. Interviewing Children**

The particular needs of a child who is thought to have communication difficulties should be considered at an early point in the planning of the enquiry (Strategy Discussion stage).

Professionals should be aware that interviewing is possible when a child communicates by means other than speech and should not assume that an interview is not possible even if it would not meet the legal standards required to be admissible as [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/).

All interviews should be tailored to the individual needs of the child and a written explanation included in the plan about any departure from usual standards.

Every effort should be made to enable such a child to tell her/his story directly to those undertaking enquiries.

Workers interviewing children should be patient; identifying need across a language barrier takes time. However, the time spent up-front will be paid back by good rapport and clear communication that will avoid wasted time and dangerous misunderstandings.

Building trust with a child or young person will also take time in order for them to open up and talk about the issue you want to discuss with them, particularly if they have been told not to talk about those issues.

Workers must remember to speak more slowly when using an interpreter to ensure information is translated correctly and allowing for the child or young person to respond, this will also promote an atmosphere of calmness.

If the child or young person  becomes anxious, distressed or overtired, check this out, and if necessary take a break.

It may be necessary to seek further advice from professionals who know the child well or are familiar with the type of impairment s/he has e.g. paediatrician at the child development centre, the child’s school and/or the social worker from the disabled children’s team.

Interviewers should be aware that some children will be perfectly fluent in English but will use their family language for intimate parts of the body.

When the child is interviewed it may be helpful for an appropriate professional to assist the interviewer and child. Careful planning is required of the role of this adviser and the potential use of specialised communication equipment.

**Investigative Interviews**

Achieving Best [Evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using [special measures](https://www.safeguardingcambspeterborough.org.uk/glossary/special-measures/) (March 2011) provides guidance on interviewing vulnerable witnesses, including learning disabilities and of the use of interpreters and intermediaries.

Interviews with witnesses with special communication needs may require use of an interpreter or [intermediary](https://www.safeguardingcambspeterborough.org.uk/glossary/intermediary/) and are generally much slower. The interview may be long and tiring for the witness and might need to be broken into 2 or 3 parts preferably (but not necessarily) held on the same day.

A witness should be interviewed in the language of her/his choice and vulnerable or intimidated witnesses, including children, may have a supporter present when being interviewed.

**4. Using Interpreters with Family Members**

If the family’s first language is not English and even if they appear reasonably fluent, the offer of an interpreter should be made, as it is essential that all issues are understood and fully explained.

Interpreters used for interviewing children should have been subject to references, DBS checks and a written agreement regarding confidentiality. Whenever possible, they should be used to interpret their own first language. In the case of FGM (see [Female Genital Mutilation Procedure](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2016/10/Practice-Guidance-for-practitioners-on-Female-Genital-Mutilation-2016-2.pdf)) the interpreter must not have any connection with the family and their cultural beliefs must be examined.

Social workers need to first meet with the interpreter to explain the nature of the investigation, aims and plan of the interview, and clarify:

* The interpreter’s role in translating direct communications between professionals and family members;
* The need to avoid acting as a representative of the family;
* When the interpreter is required to translate everything that is said and when to summarise;
* That the interpreter is prepared to translate the exact words that are likely to be used – especially critical for sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* When the interpreter will explain any cultural issues that might be overlooked (usually at the end, unless any impede the process);
* The interpreter’s availability to interpret at other interviews and meetings and provide written translations of reports (taped versions if literacy is an issue).

Family members may choose to bring their own interpreter as a supporter.

Invitations to child protection conferences and reports must be translated into a language / medium that is understood by the family.

**Dangerous dogs**

**Aims of this Guidance**

The benefits of owning pets are well established. Having a pet can have physical and emotional benefits for a child as well as teaching them about responsibility and caring for living creatures. However, a number of children of different ages have been seriously injured or have died from attacks by dogs in recent years.

The primary aim of this guidance is to protect children in Cambridgeshire and Peterborough from the serious injuries that can be inflicted by dogs that are prohibited, dangerous or poorly managed.

The guidelines set out to explain and describe:

* The children most likely to be vulnerable and the dogs most likely to be dangerous;
* The information that should be gathered when any child is injured by a dog and the criteria that should prompt a referral to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/);
* The basis for an effective assessment of risk and the options for action that could be considered by strategy groups or case conferences

Research suggests that [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of animals can be part of a constellation of intra-familial violence, which can include maltreatment of children and domestic violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). However, this does not imply that children who are cruel to animals necessarily go on to be violent adults, or that adults who [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)animals are also violent to their partners and/or children. Effective investigation and assessment are crucial to determine whether there are any links between these factors and the possible risks to the safety and welfare of children and/or vulnerable adults.

**Dangerous Dogs**

The Dangerous Dogs Act (1991) (amended with effect from 13 May 2014 by the Antisocial Behaviour, Crime and Policing Act 2014) provides detailed information on the legislation covering certain types of dogs, the responsibilities of owners and the actions that can be taken to remove and/or control dogs. As a result of the 2014 Act, it extends to private places, the offence of owning or being in charge of a dog that is dangerously out of control (previously in a public place); provides that a dog attack on an assistance dog constitutes an aggravated offence; and ensures that the courts can take account of the character of the owner of the dog, as well as of the dog, when assessing whether a dog should be destroyed on the grounds that it is a risk to the public;

**Any dog can be ‘dangerous’ (as defined by The Act) if it has already been known to inflict or threaten injury**

**A dog can also be defined as “dangerously out of control” by the Act**:  *“For the purposes of this Act a dog shall be regarded as dangerously out of control on any occasion on which there are grounds for reasonable apprehension that it will injure any person or assistance dog, whether or not it actually does so”*

Certain dogs are ‘prohibited’ and if any agency has any knowledge or report of a dog of this type, **the matter should be reported to the**[**police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)**immediately.**Prohibited breeds are defined by the Act as “any dog of the type known as Pit Bull Terrier, the Japanese Tosa, the Dogo Argentino and the Fila Braziliero”

Injuries inflicted by certain types of dog are likely to be especially serious and damaging. Strong, powerful dogs such as Pit Bull Types will often use their back jaws (as opposed to ‘nipping’) and powerful neck muscle to shake their victims violently as they grasp;

When reports of ‘prohibited’ dogs and known or potentially dangerous dogs are linked to the presence of children, all agencies should be alert to the possible risks and consequences.

**The Dog and the Child: Family Context**

When you visit a family that has a dog you need to consider whether or not the dog poses any threat to the child’s health, development or safety.

* All children are potentially vulnerable from attack(s) from dog(s);
* Young and very small children are likely to be at greatest risk;
* A young child may be unaware and unprepared for the potential dangers they could face;
* A young child may less able to protect themselves and more likely to be of a size that leaves especially vulnerable parts of their body exposed to any ‘assault’;
* Is it a large dog in a small home;
* Is the dog left alone with the child;
* How much money is spent on the dog compared to the child;
* **If you consider a dog is a serious risk to a child you should contact the**[**police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)**immediately**.

**Owners and Families (including extended family and temporary carers)**

* Many commentators will insist that ‘the owner, not the dog’ is the problem;
* There will be occasions when even the ‘best’ of owners fails to anticipate or prevent their dog’s behaviour;
* The care, control and context of a dog’s environment will undoubtedly impact on their behaviour and potential risks;
* Research indicates that neutered or spayed dogs are less likely to be territorial and aggressive towards other dogs and people;
* Dogs that are kept and/or bred for the purpose of fighting, defending or threatening are likely to present more risks than genuine pets;
* Some dogs are kept as a status symbol and can be part of the criteria of belonging to a gang.

**Owners:**

* Owners linked to criminal activity, anti-social behaviour, drugs or violence may have reason to encourage aggressive behaviour from dogs;
* Owners with interests and histories in crime, violence, drugs or anti-social behaviour are unlikely to appreciate or prevent the possible risks their dog(s) present to children;

**Families characterised by high levels of aggression and domestic tensions:**

* Are more likely to trigger excitement and possible attacks by dogs;
* Are less likely to appreciate and anticipate risks;
* May be less likely to take necessary precautions;
* May be less likely to guarantee the safety of the most vulnerable youngsters;
* Very young, small children living in chaotic or dysfunctional families are likely to be especially vulnerable;

Prohibited, dangerous, powerful dogs are likely to inflict the most serious injuries.

**Practitioner Guidance**

Any agency aware of a dog that could be prohibited or considered dangerous should collect as much information as possible:

* The dog’s name and breed;
* The owner’s details;
* Clear discussions with the owner regarding planned management of the dog where there are children in the household or wider family.
* Where the agency/individual is unsure; advice should be sought from [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) colleagues.

**Risk Factors: Dangerous Dogs**

1. Is the dog’s owner usually present?
2. Is the dog exercised outside the property?
3. Does the dog have off lead exercise? Does the dog live in a yard/garden?
4. Does the dog destroy/chew things?
5. Has the dog ever been involved in a biting incident with another dog?
6. Has the dog ever bitten a person?
7. Was the dog chosen for its breed or its temperament?
8. Does the owner have any previous convictions?
9. What size is the dog?
10. Is the dog fed from human plates at mealtimes?

**Any agency:**

* Aware of an injury to a child caused by a dog;
* Or treating an injury to a child caused by a dog;
* Should establish precisely when and how the injuries were caused;
* **If and when there is any history of previous, similar injuries.**

Consideration should be given to whether the injuries caused are **“non accidental injuries”.**

**Referral to Children’s Social Care:**

A referral should be considered if any of the following criteria apply:-

* The child injured is under two years of age;
* The child is under five years of age and injuries have required medical treatment;
* The child is over five years and under 16 and has been injured more than once by the same dog;
* The child is between five years and 18 years and the injuries are significant;
* The child/young person is under 16 years of age, injuries have required medical treatment and initial information suggests the dog responsible could be prohibited and/or dangerous;
* A prohibited and/or dangerous dog is reported and/or treated, and is believed to be living with and/or frequently associated with children under five years.

Some referrals might be logged ‘for information’ only if there is very clearly no significant or continued risk to the child, or other children (for example, if the dog has already been ‘put down’ or removed).

Some referrals might prompt information on dogs and safe care of children if the incident or injury was clearly minor, if the child was older or if the family have clearly shown themselves to be responsible dog owners.

**More serious cases might prompt further and more formal discussions with other agencies including Strategy meetings**:

* Home visits to complete fuller assessments and to inform judgements on parenting and the care and control of dog(s
* Advice might be sought from a vet to help determine the likely nature or level of risk presented by the dog(s).

As with all other assessments **“the welfare of the child is paramount”**.

**If agencies cannot be satisfied that any further risks will be addressed, they should consider all statutory options open to them to protect the child or remove the dog(s).**

**Significant Issues**

The RSPCA advice to all professionals who are in contact with a household where there is a dog/s present:

‘’When looking at, or asking about a dog think about the following points, which should not be considered an exhaustive list but are intended to prompt a professional’s curiosity as to the state of the dog’s welfare along with suggested courses of action.‘’

‘’The points relate to Section 9 of the Animal Welfare Act, 2006 which imposes a duty of care on a person who is permanently or temporarily responsible for an animal. This duty of care requires that reasonable steps in all the circumstance are taken to ensure that the welfare needs of an animal are met to the extent required by good practice. The welfare needs are:

* The need for a suitable environment;
* The need for a suitable diet;
* The need to be able to exhibit normal behaviour patterns;
* The need it has to be housed with, or apart from, other animals;
* The need to be protected from pain, suffering, injury and disease.

During the visit ask if there is a dog in the property including the back garden. If there is, and the dog isn’t in the same room as you, ask to see him.’’

**Further Information**

[**Dangerous Dogs Resource Pack:**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/Dangerous-Dogs-Pack-2020.pdf)**which includes:**

[**Institute of Health Visiting: Keeping babies and children safe around dogs**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/3-iHV_PT_Keeping_babies_and_children_safe_around_dogs_April_2017_web.pdf)

[**RSPCA How kids SHOULD NOT interact with dogs**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/4-RSPCA_KeepingKidsSafe_postersA3_p1.pdf)

[**RSPCA How kids SHOULD interact with dogs**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/5-RSPCA_KeepingKidsSafe_postersA3_p2.pdf)

[**RSPCA Dogs and Children – guide to staying safe**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/6-Dogs-and-Children-guide-to-staying-safe.pdf)

[**The Dogs Trust: Staying Safe With Dogs**](https://www.dogstrust.org.uk/help-advice/factsheets-downloads/stay%20safe%20around%20dogs.pdf)

[**Bluecross – Keeping your toddler safe around dogs**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/8-dog-safety-around-toddlers-Bluecross.pdf)

[**Bluecross – Your dog and your baby**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/08/9-DOG_AND_BABY-Bluecross.pdf)

[**The Blue Cross Be Safe with Dogs Leaflet – Guidance for Families**](https://www.bluecross.org.uk/sites/default/files/downloads/14865_proof_4LR_WEB.pdf)

Battersea Dogs and Cats Home ([**battersea.org.uk**](https://www.battersea.org.uk/pet-advice)**)** has made this 7 minute animated film to keep children safe around animals: [**https://youtu.be/FhV3YIR3q1A**](https://youtu.be/FhV3YIR3q1A)

[**Kennel Club’s Safe & Sound Programme with Resources for Schools**](http://www.thekennelclub.org.uk/training/safe-and-sound/)

[**National Animal Welfare Trust Advice Sheet/Free Webinar**](http://www.nawt.org.uk/advice/changes-dangerous-dogs-act-advice%20-owners)

**Disabled children**

**1. Introduction**

It is a fundamental principle that disabled children have the same right as non-disabled children to be protected from [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and [**Abuse**](http://trixresources.proceduresonline.com/nat_key/keywords/abuse.html). However in order to ensure that the welfare of disabled children is safeguarded and promoted, it needs to be recognised that additional action is required. This is because disabled children have additional needs related to physical, sensory, cognitive and/or communication requirements and many of the problems they face are caused by negative attitudes, prejudice and unequal access to things necessary for a good quality of life.

Disabled children are likely to have poorer outcomes across a range of indicators including low educational attainment, poorer access to health services, poorer health outcomes and a more focussed need to prepare for adulthood. They are more likely to suffer family break up and are significantly over-represented in the populations of [**Looked After Children**](http://trixresources.proceduresonline.com/nat_key/keywords/looked_after_child.html).

Where disabled children are looked after they are more likely to be placed in residential care rather than family settings, which in turn increases their vulnerability to [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

Families with disabled children are more likely to experience poverty and children with [**Special Educational Needs**](http://trixresources.proceduresonline.com/nat_key/keywords/spec_edu_needs.html) are more likely to be excluded from school, (70% of all permanent exclusions are if pupils with SEN).

Research [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) suggests that disabled children are at increased risk of [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and Neglect, and that the presence of multiple disabilities appears to increase the risk of both [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and [**Neglect**](http://trixresources.proceduresonline.com/nat_key/keywords/neglect.html), yet they are underrepresented in safeguarding systems. Disabled children are more vulnerable to [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and Neglect (e.g. due to their reliance on their personal care being delivered by more than 1 adult). Early indicators suggestive of [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and Neglect can be more complicated for disabled children.

Whilst the practice guidance does not identify specific groups of disabled children, particular reference is made to children with speech, language and communication needs. This includes those who use non-verbal means of communication as well a wider group of children who have difficulties communicating with others.

The guidance emphasises the critical importance of communication with disabled children including recognising that all children can communicate their views, wishes and feelings if asked in the right way by those who understand their needs and have the skills to listen to them.

Various definitions of disability are used across agencies and professionals. Whatever definition of ‘disabled’ is used, the key issue is not what the definition is but the impact of [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or Neglect on a child’s health, development and [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/), and consideration of how best to safeguard and promote the child’s welfare.

**2. Practice Guidance for All Professionals**

The reasons why disabled children are more vulnerable to [**Abuse**](http://trixresources.proceduresonline.com/nat_key/keywords/abuse.html) are summarised below:

* 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 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;
* 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](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) because of their additional dependency on residential and hospital staff for day to day physical needs.

Where there are safeguarding concerns about a disabled child, there is a need for greater awareness of the possible indicators of [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and/or Neglect as the situation is often more complex. It is crucial that the disability is not allowed to mask or deter the need for an appropriate investigation of [**Child Protection**](http://trixresources.proceduresonline.com/nat_key/keywords/child_protection.html) concerns.

The following are some indicators of possible [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or Neglect:

* A bruise in a site that might not be of concern on an ambulant child, such the shin, might be a concern on non-mobile child;
* Not getting enough help with feeding leading to malnourishment;
* Poor toileting arrangements;
* Lack of stimulation;
* Unjustified and/or excessive use of restraint;
* Rough handling, extreme behaviour modification e.g. deprivation of liquid, medication, food or clothing;
* Unwillingness to try to learn a child’s means of communication;
* Ill-fitting equipment e.g. callipers, sleep boards, inappropriate splinting, misappropriation of a child’s finances;
* Invasive procedures which are unnecessary or are carried out against the child’s will;
* If insufficient time is given for a child with restricted arm and hand movement to have an adequate lunch, the child could experience hunger or dehydration. The impact of such an experience is repeated over a number of days could be considerable;
* Removing batteries out of an electric wheelchair to restrict liberty solely for the convenience of staff might equate to a non-disabled child being locked in a room or having their legs tied.

Professionals may be reluctant to act on concerns because of a number of factors that include:

* Over identifying with the child’s parents/carers and being reluctant to accept that [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or Neglect is taking or has taken place, or seeing it as being attributable to the stress and difficulties of caring for a disabled child;
* A lack of knowledge about the impact of disability on the child;
* A lack of knowledge about the child, e.g. not knowing the child’s usual behaviour;
* Not being able to understand the child’s method of communication;
* Confusing behaviours that may indicate the child is being Abused with those associated with the child’s disability;
* Denial of the child’s sexuality;
* Behaviour, including sexually harmful behaviour or self-injury, may be indicative of [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* Being aware that certain health/medical complications may influence the way symptoms present or are interpreted. For example some particular conditions cause spontaneous bruising or fragile bones, causing fractures to be more frequent.

Those in Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) who are likely to receive initial contacts and/or referrals concerning disabled children should have received appropriate training to equip them with the knowledge and awareness to assess the risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child and know what action to take.

Assessment should be undertaken by professionals who are both experienced and competent in child protection work, with additional input from those professionals (and external agencies) who have knowledge and expertise of working with disabled children.

A good question when assessing a disabled child is: Would I consider that option if the child were not disabled?

Extra resources may be necessary especially where the child has speech, language and communication needs. For example it may be necessary to obtain an assessment from a teacher and speech and language specialist as to the best way of working with the child.

The child’s preferred method of communication must be given the utmost priority.

The following questions should be asked when a referral is received concerning a disabled child:

* What is the disability, special need or impairment that affects the child? Ask for a description of the disability or impairment;
* How does the disability or impairment affect the child on a day-to-day basis?
* How does the child communicate? If someone says the child cannot communicate, simply ask the question: ‘How does the child indicate he or she wants something?
* How does the child show s/he is unhappy / in pain / have concerns?
* Has the disability or condition been medically diagnosed?

The number of carers involved with the child should be established as well as where the care is provided and when.

At the [**Strategy Discussion**](http://trixresources.proceduresonline.com/nat_key/keywords/strategy_discussion.html), if a facilitator or interpreter is required, he or she should be involved when planning the investigation.

Where an interview with the disabled child is needed, consideration should be given to whether any additional equipment or facilities are required and whether someone with specialist skills in the child’s preferred method of communication should be involved.

All those involved in an investigation must ensure that they communicate clearly with the disabled child and the family as well as with each other as there are likely to be a greater number of professionals involved.

**Faiths**

**1. Definition**

For the purposes of this policy the term *‘*[*abuse*](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)*linked to faith or belief’* includes belief in witchcraft, spirit possession, demons or the devil, the evil eye or djinns, dakini, kindoki, ritual or muti killings and use of fear of the supernatural to make children comply with, for example, being trafficked for domestic slavery or sexual exploitation.  Genuine beliefs can be held by children, families, carers and religious leaders that evil forces have entered the child and are controlling him or her.  [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) may occur when an attempt is made to ‘exorcise’ the child.

The beliefs which are the focus of this policy/ procedure are not confined to one faith, nationality or ethnic community.

**2. Risks**

The number of known cases suggests that only a small minority of people who believe in witchcraft or spirit possession go on to [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) children.  However, the children involved can suffer damage to their physical and mental health, their capacity to learn, their ability to form relationships and to their self-esteem.

[Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) may happen anywhere, but it most commonly occurs within the child’s home.  Such [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) generally occurs when a [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/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.  The attempt to ‘exorcise’ may involve severe beating, burning, starvation, cutting or stabbing and isolation, and usually occurs in the household where the child lives although it may also occur in a place of worship.

A range of factors can contribute to the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of a child for reasons of faith or belief.  Some of the most common ones are listed below:

* **Belief in evil spirits:** Belief in evil spirits that can ‘possess’ children is often accompanied by a belief that a possessed child can ‘infect’ others with the condition.  This could be through contact with shared food, or simply being in the presence of the child.
* **Scapegoating:** A child could be singled out as the cause of misfortune within the home, such as financial difficulties, divorce, infidelity, illness or death.
* **Bad Behaviour:** Sometimes bad or abnormal behaviour is attributed to spiritual forces. Examples include a child being disobedient, rebellious, overly independent, wetting the bed, having nightmares or falling ill.
* **Physical differences:** A child could be singled out for having a physical difference or disability. Documented cases include children with learning disabilities, mental health issues, epilepsy, autism, stammers and deafness.
* **Gifts and uncommon characteristics:** If a child has a particular skill or talent, this can sometimes be rationalised as the result of possession or witchcraft. This can also be the case if the child is from a multiple or difficult pregnancy.
* **Complex family structure/changes in family structure:** Research suggests that a child living with extended family, non-biological parent or foster parents is more at risk. In these situations, they are more likely to have been subject to trafficking and made to work in servitude.

**3. Indicators**

In working to identify such child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) it is important to remember every child is different.  Some children may display a combination of indicators of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) whilst others will attempt to conceal them.  In addition to the factors above, there are a range of common features across identified cases.  These indicators of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), which may also be common features in other kinds of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), include:

* a child’s body showing signs or marks, such as bruises or burns, from physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)
* a child becoming noticeably confused, withdrawn, disorientated or isolated and appearing alone amongst other children;
* a child’s personal care deteriorating, for example through a loss of weight, being hungry, turning up to school without food or lunch money, or being unkempt with dirty clothes and even faeces smeared on to them;
* it may be directly evident that the child’s parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) does not show concern for or have a close bond with the child;
* a child’s attendance at school becoming irregular or the child being taken out of school altogether without another school place having been organised, or a deterioration in a child’s performance at school;
* a child reporting that they are or have been accused of being ‘evil’, and/or that they are having the ‘devil beaten out of them’.

All agencies should be alert to the indicators above and should be able to identify children at risk of this type of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and intervene to prevent it.

**4. Protection and action to be taken**

Any practitioner who comes in to contact with children should be able to recognise [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) that a child is being abused or neglected, and know what to do to safeguard and promote the welfare of a child.  This may be the crucial intervention that protects the child from further [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect.  In any situation in which there are concerns for the safety and welfare of a child the Referrals Procedure must be followed.

Where there are concerns that a child is suffering or likely to suffer **Significant**[**Harm**](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) will convene a **Strategy Discussion / Meeting** involving health, [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and other relevant agencies. See [**Action to be taken where a child is suffering or likely to suffer significant harm**.](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/action-to-be-taken-where-a-child-is-suffering-or-likely-to-suffer-significant-harm/)

The strategy discussion / meeting should give particular consideration to:

* Whether the beliefs are supported by others in the family or in the community and whether this is an isolated case or if other children from the same community are being treated in a similar manner;
* Practitioners need to establish if there is a faith community and leader to which the family and the child adhere;
* The details of the faith leader and faith community which the family and child adhere to;
* The exact address of the premises where worship or meetings take place;
* Further information about the beliefs of the adherents and whether they are aligned to a larger organisation in the UK or abroad (websites are particularly revealing in terms of statements of faith and organisational structures);
* If there is a designated safeguarding lead within the faith community or larger organisation.

Given the potentially complex nature of Section 47 enquiries it may be appropriate to hold additional strategy discussions to ensure that informed decisions are made. Where a community or organisation is involved in the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), consideration should be given to following the [**Organised and Complex Abuse Procedure**.](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/organised-and-complex-abuse/)

When working with a child and their family particular consideration should be given to:

* Building a relationship of trust with the child, and whether there is another professional who already has a trusting relationship with the child;
* Whether to involve the family. A child who is believed to be possessed may be stigmatised in their own family. If the child has been labelled as possessed, professionals should find out how this affects the child’s relationship with others in the extended family and community;
* What the beliefs of the family are;
* Where to obtain expert advice about cultures or beliefs that are not their own;
* What pressures the family are under. These cases of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) will sometimes relate to blaming the child for something that has gone wrong in the family. Professionals should consider whether there is anything that can or should be done to address relevant pressures on the family; and
* That the abuser may have a deeply held belief that they are delivering the child of evil spirits and that they are not harming the child but actually helping them. Holding such a belief is no defence or mitigation should a child be abused.

Consideration should also be given to the child and family’s communication needs, particularly if English is not their first language. If required a professional interpreter should be provided; family or community members should **NOT** be asked to act as interpreters.

Where a child is from a migrant community, particular care should be taken to assess the risk of that child being taken out of the county to avoid investigation. Legal advice and [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) action should be considered.

Where it is believed a professional or someone in a position if trust is involved in the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), consideration should also be given to the [**Managing Allegations Against Staff, Carers and Volunteers Procedure**.](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/managingallegations/)

[Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) linked to a belief in spirit possession can be hard for professionals to accept and it may be difficult to understand what they are likely to be dealing with; it can often take a number of visits to recognise such [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).  In cases of suspected [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) linked to a belief in spirit possession it may be particularly useful to consider the following questions:

1. What are the beliefs of the family?
2. What is the family structure?
3. Are there reasons why the child might be picked on?
4. Do I need a professional interpreter?
5. What is the preferred language of the child and family?

Practitioners should seek advice if dealing with a culture or set of beliefs that they do not understand, or which are unfamiliar to you. Practitioners need to have an understanding of religious beliefs and cultural practices in order to help gain the trust of the family or community.

An assessment should aim to fully understand the background and context to the beliefs and should involve the particular faith group or person advising the family about the child in order to establish the facts i.e. what is happening to the child. Consideration should be given to asking an independent person to act as an adviser and mediator.

The assessment may include key people in the community especially when working with new immigrant communities and different faith groups.  In view of the nature of the risks, a full health assessment of the child should take place to establish the overall health of the child, the medical history and current circumstances.

Any suggestions that the parent or carers will take the child out of the country must be taken seriously and legal advice sought regarding possible prevention. The child must be seen and spoken to on his or her own. The child’s sleeping and living arrangements must be inspected.

In assessing the risks to the child, the siblings or any other children in the household must also be considered as they may have witnessed or been forced to participate in abusive activities.

**5. Issues**

The accusation of witchcraft dehumanises and criminalises the child thereby opening the door for many forms of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) including, physical, [emotional abuse](http://westmidlands.procedures.org.uk/page/glossary?term=Emotional+abuse&g=0gjN#gl18) and [neglect](http://westmidlands.procedures.org.uk/page/glossary?term=Neglect&g=zcjN#gl7) while at the same time putting the child at risk of [sexual abuse](http://westmidlands.procedures.org.uk/page/glossary?term=Sexual+abuse&g=1cjN#gl9).

Concerns about places of worship may emerge where:

* A lack of priority is given to the protection of children and there is reluctance by some leaders to get to grips with the challenges of implementing sound safeguarding policies or practices;
* Assumptions exist that ‘people in our community’ would not [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) children or that a display of repentance for an act of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is seen to mean that an adult no longer poses a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* There is a denial or minimisation of the rights of the child or the demonisation of individuals;
* There is a promotion of mistrust of secular authorities;
* There are specific unacceptable practices that amount to [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

**6. Further information**

Further contacts for advice can be found from the local representatives for some faiths.

* [An Exploration of Knowledge About Child Abuse Linked to Faith or Belief](http://vcf-uk.org/wp-content/uploads/2016/11/An-Exploration-of-Knowledge-about-Child-Abuse-linked-to-Faith-or-Belief.pdf) (2016)
* [National Action Plan to Tackle Child Abuse Linked to Faith or Belief](https://www.gov.uk/government/publications/national-action-plan-to-tackle-child-abuse-linked-to-faith-or-belief) (2012)
* [Safeguarding Children from Abuse Linked to a Belief in Spirit Possession](http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/standard/publicationDetail/Page1/DFES-00465-2007) (2007) this good practice guidance is archived but still available.
* [Eleanor Stobart report 2006: Child Abuse Linked To Accusations of Possession And Witchcraft (2006)](http://dera.ioe.ac.uk/6416/1/RR750.pdf)
* [Unicef study report: Children Accused of Witchcraft](https://www.unicef.org/wcaro/wcaro_children-accused-of-witchcraft-in-Africa.pdf)
* [AFRUCA: Africans Unite Against Child Abuse](http://www.afruca.org/)

**7. Law**

There are a number of laws in the UK that allow the prosecution of those responsible for [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) linked to faith or belief. One of the biggest challenges is raising awareness and encouraging victims and witnesses to come forward.

**Children Act 1989**

Section 47 of the Children Act 1989 empowers LA’s to investigate a referral that a child may have suffered or is at risk of suffering [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). Whilst the Children Act 1989 does not mention the terms witchcraft or spirit possession, it does clarify what constitutes child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), which can include [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through witchcraft or spirit possession.

**Children Act 2004**

Under Section 11 of the Children Act 2004, government bodies and agencies must ‘make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children.’ This applies to children’s services, Health bodies and Trusts and [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) authorities (including transport [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)).

**Forced marriage**

**1. Definition**

There is a clear difference between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice of whether or not to accept the arrangement remains with the young people.

In a forced marriage, one or both spouses do not [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to the arrangement of the marriage and some elements of duress are involved. Duress can include physical, psychological, financial, sexual and emotional pressure. Forced Marriage is an [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of human rights and, where a child is involved, an [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of the rights of the child.

Forced marriage involving anyone under the age of 18 constitutes a form of child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). A child who is forced into marriage is likely to suffer Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through physical, sexual or emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Forced marriage can have a negative impact on a child’s health and development, and can also result in sexual violence including rape. If a child is forced to marry, he or she may be taken abroad for an extended period of time which could amount to child abduction. In addition, a child in such a situation would be absent from school resulting in the loss of educational opportunities, and possibly also future employment opportunities. Even if the child is not taken abroad, they are likely to be taken out of school so as to ensure that they do not talk about their situation with their peers.

**2. Risks**

One serious consequence of forced marriage is the increased likelihood of domestic violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Anyone forced into marriage faces an increased risk of rape and sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) as they may not [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), or may not be the legal age to [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to a sexual relationship. This in turn may result in unwanted pregnancies or enforced abortions.

Female Genital Mutilation may also be a factor in cases of forced marriage. See also [**Female Genital Mutilation Practice Guidance**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2016/10/Practice-Guidance-for-practitioners-on-Female-Genital-Mutilation-2016-2.pdf).

Circumstances can change quickly and increase the risk to the victim and any friends/family members supporting the victim – especially following a disclosure to the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/). Perpetrators may respond by moving the victim or bringing forward a forced marriage.

Perpetrators will use controlling and coercive methods to control the victim.

Women, men and younger members of the family can all be involved in perpetrating the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Offences that may be committed include; common assault, grievous bodily [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), harassment, false imprisonment, kidnap, threats to kill and murder. There may be instances of child trafficking.

Perpetrators may take victims abroad for the purpose of forced marriage, under the pretext of a family holiday, a wedding or illness of a grandparent/family member.

The risks of emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) through being stigmatised by family wider community are also present; these in turn may lead to serious consequences for the individual in terms of their mental health or self-harming behaviour.

Children are also deprived of the normal range of opportunities and experiences available to their peers when they are pressurised into marriage against their will.

**3. Indicators**

Warning signs that a child or young person may be at risk of forced marriage or may have been forced to marry may include:

* Extended absences from school/college, truancy, drop in performance, low motivation, excessive parental restriction and control of movements and history of siblings leaving education early to marry;
* A child talking about an upcoming family holiday that they are worried about, fears that they will be taken out of education and kept abroad;
* [Evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), treatment for depression, attempted suicide, social isolation, eating disorders or substance [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* [Evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of family disputes/conflict, domestic violence/[abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or running away from home;
* Unreasonable restrictions such as being kept at home by their parents (’house arrest’) or being unable to complete their education;
* A child being in conflict with their parents;
* A child going missing/running away;
* A child always being accompanied including to school and doctors’ appointments;
* A child directly disclosing that they are worried s/he will be forced to marry;
* Contradictions in the child’s account of events.

See also the [**Multi-agency Practice Guidelines on Forced Marriage Chart of Potential Warning Signs or Indicators**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf#page=20).

**4. Legal Position**

Anyone threatened with forced marriage or forced to marry against their will can apply for [**Forced Marriage Protection Order**](http://trixresources.proceduresonline.com/nat_key/keywords/force_marriage_prot_ord.html). Third parties, such as relatives, friends, voluntary workers and [police](https://www.safeguardingcambspeterborough.org.uk/glossary/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 seek a protection order for [**Adults at Risk**](http://trixresources.proceduresonline.com/nat_key/keywords/adult_at_risk.html) 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. (This is available at the Justice website).

The Anti-social Behaviour, Crime and Policing Act 2014 made it a criminal offence, with effect from 16 June 2014, to force someone to marry. This includes:

* Taking someone overseas to force them to marry (whether or not the forced marriage takes place);
* Marrying someone who lacks the mental [**Capacity**](http://trixresources.proceduresonline.com/nat_key/keywords/capacity.html) to [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to the marriage (whether they’re pressured to or not).

Breaching a Forced Marriage Protection Order is also now a criminal offence. The civil remedy of obtaining a Forced Marriage Protection Order through the family courts, as set out above,  continues to exist alongside the criminal offence, so victims can choose how they wish to be assisted.

Forcing someone to marry can result in a sentence of up to 7 years in prison.

Disobeying a Forced Marriage Protection Order can result in a sentence of up to 5 years in prison.

**5. Protection and Action to be Taken**

Where the concerns about the welfare and safety of the child or young person are such that a referral to Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should be made the procedures [**Cambridgeshire Making Referrals to MASH**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/referralstomash/) and [**Peterborough Making Referrals to Children Social Care**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/making-referrals-to-childrens-social-care/) must be followed.

Practitioners should always consider the need for immediate protection, as disclosure of the forced marriage may be the direct consequence of the impending event. Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) will liaise with the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) to ensure the safety of the victim and any other family members.

A [**Strategy Discussion/Meeting**](http://trixresources.proceduresonline.com/nat_key/keywords/strategy_discussion_meeting.html) will be needed to deal with this issue; the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), Housing Services, Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), Health and voluntary organisations must work together to address the young person’s need for information, protection, financial support, accommodation and emotional support. Legal advice will be needed to inform the Strategy Discussion as legal action may be necessary.

Any child considered to be at risk of a forced marriage will be considered a child in need and assessed accordingly. Where an [**Initial Child Protection Conference**](http://trixresources.proceduresonline.com/nat_key/keywords/init_chi_prot_conf.html) is convened, great care must be taken to manage information about the whereabouts of the young person. The social worker and his/her manager must discuss the arrangements with the Conference Chair and consider whether the family should be present or not, or at the same time as the young person, as threats may be made. An interpreter fully independent of the family should be present at all times.

**6. Issues**

Allegations of plans and arrangements to force a child to marry will inevitably be divisive for the family and possibly the wider community. Therefore attempts to discuss this with the family could potentially place a child at greater risk.

Children may require support from workers of the same gender and if possible the same cultural background. Where interpreters and translators are used, care must be taken to ensure that they have no connections with the immediate community of the child.

A child arriving in this country for the purposes of a forced marriage or one who has recently married abroad may be extremely isolated and feel threatened and abused. The legal right to remain may be in question and the consequences of returning home may also be very serious.

Professionals should not:

* Underestimate the potential risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* Speak to the child on the telephone (to ascertain if they are being held against their will) – the family may be present or it may be a different person speaking on the telephone;
* Approach or inform the child’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;
* Share information outside child protection information-sharing protocols without the express [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) of the child;
* Attempt to be a mediator. This has in the past resulted in the victim being removed from the country and not traced /or murdered.

**7. Further Information**

[**The Right to Choose – Multi Agency Statutory Guidance for Dealing with Forced Marriage**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf) (2014) – Guidance for all persons and bodies who exercise public function in relation to safeguarding and promoting the welfare of children and vulnerable adults.

[**Multi-Agency practice guidelines: Handling cases of forced marriage (2014)**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf) – Step-by-step advice for frontline workers. Essential reading for health professionals, educational staff, [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), adult social services and local authority housing.

[**Forced Marriage and Learning Disabilities Multi-agecny Practice Guidelines**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/03/Forced-Marriage-and-Learning-Disabilities-Multi-agecny-Practice-Guidelines.pdf) – the Forced Marriage Unit published *multi*–*agency practice guidelines* around *forced marriage* and people with *learning disabilities*

[**The Forced Marriage Unit (GOV.UK)**](https://www.gov.uk/stop-forced-marriage)– Contact the Forced Marriage Unit (FMU) if you’re trying to stop a forced marriage or you need help leaving a marriage you’ve been forced into.

[**Home Office**](https://www.gov.uk/forced-marriage) – Information and practice guidelines for professionals protecting, advising and supporting victims. This includes Multi-Agency Statutory Guidance for dealing with forced marriage.

**Gangs**

**1. Definition**

[Serious Crime Act 2015 Section 51](http://www.legislation.gov.uk/ukpga/2015/9/section/51/enacted) defines a gang as:

Something is “gang related “if it occurs in the course of, or is otherwise related to the activities of a group that:

1. Consists of at least three people; and
2. Has one or more characteristics that enable its members to be identified by other as a group”.

[County Lines](https://www.safeguardingcambspeterborough.org.uk/glossary/county-lines/) definition NCA 2016:

“Section 34(7) of the Policing and Crime Act 2009 defines gang related drug dealing activity as ”the unlawful production, supply,importation or exportation of a controlled drug which occurs in the course of, or is otherwise related to,the activities of a group that:

1. Consists of at least three people; and
2. Has one or more characteristics that enable its members to be identified by other as a group”.

**2. Risks**

The risk or potential risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child may be as a victim, a perpetrator or both – in relation to their peers or to a gang-involved adult in their household. Teenagers can be particularly vulnerable to recruitment into gangs and involvement in gang violence. This vulnerability may be exacerbated by risk factors in an individual’s background, including violence in the family, involvement of siblings in gangs, poor educational attainment, or mental health problems.

A child who is affected by gang activity or serious youth violence can be at risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through physical, sexual and emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Girls and boys may be particularly at risk of sexual exploitation.

Violence is a way for gang members to gain recognition and respect by asserting their power and authority in the street, with a large proportion of street crime perpetrated against members of other gangs or the relatives of gang members.

The specific risks for males and females may be quite different. There is a higher risk of sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) for females and they are more likely to have been coerced into involvement with a gang through peer pressure than their male counterparts. However practitioners must be aware that boys and young men are also vulnerable to this type of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

There is [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of a high incidence of rape of girls who are involved with gangs. Some senior gang members pass their girlfriends around to lower ranking members and sometimes to the whole group at the same time. Very few rapes by gang members are reported. Boys and young men are less likely to report rape or sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) due to factors such as (but not limited to); stigma, fear of not being believed, shame, embarrassment, homophobia.

Gang members often groom girls at school using drugs and alcohol, which act as disinhibitors and also create dependency, and encourage / coerce them to recruit other girls through school / social networks.

**3. Indicators**

* Child withdrawn from family;
* Sudden loss of interest in school or change in behaviour. Decline in attendance or academic achievement (although it should be noted that some gang members will maintain a good attendance record to avoid coming to notice);
* Being emotionally ‘switched off’, but also containing frustration / rage;
* Starting to use new or unknown slang words;
* Holding unexplained money or possessions;
* Staying out unusually late without reason, or breaking parental rules consistently;
* Sudden change in appearance – dressing in a particular style or ‘uniform’ similar to that of other young people they hang around with, including a particular colour;
* Dropping out of positive activities;
* New nickname;
* Unexplained physical injuries, and/or refusal to seek / receive medical treatment for injuries;
* Graffiti style ‘tags’ on possessions, school books, walls;
* Constantly talking about another young person who seems to have a lot of influence over them;
* Breaking off with old friends and hanging around with one group of people;
* Associating with known or suspected gang members, closeness to siblings or adults in the family who are gang members;
* Starting to adopt certain codes of group behaviour e.g. ways of talking and hand signs;
* Expressing aggressive or intimidating views towards other groups of young people, some of whom may have been friends in the past;
* Being scared when entering certain areas; and
* Concerned by the presence of unknown youths in their neighbourhoods.

An important feature of gang involvement is that, the more heavily a child is involved with a gang, the less likely they are to talk about it.

There are links between gang-involvement and young people going missing from home or care. Some of the factors which can draw gang-involved young people away from home or care into going missing can come through the drugs markets and ‘drugs lines’ activity. There may be gang-associated child sexual exploitation and relationships which can be strong pull factors for girls and boys. Exploitation is at the heart of this activity, with overt coercion taking place alongside the pull factors of money, status, affection and belonging.

In suspected cases of radicalisation, social workers and local authorities are under a duty to refer the case to the local Channel panel, which will then decide the correct, if any, intervention and support to be offered to that individual.

**4. Protection and Action to be Taken**

Any agency or practitioner who has concerns that a child may be at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) as a consequence of gang activity should contact Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) or the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) for the area in which the child is currently located. The [Making Referrals to MASH Procedure](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/referralstomash/) (for Cambridgeshire) and the [Making Referrals to Children Social Care Procedure](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/making-referrals-to-childrens-social-care/) (for Peterborough) should be followed. The Early Help Assessment (EHA) may be crucial in the early identification of children and young people who need additional support due to risk of involvement in gang activity.

Support and interventions should be proportionate, rational and based on the child’s needs identified during the assessment.

A Child in Need Assessment should be led by a qualified social worker and [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) and information sharing across all relevant agencies will be key. It may be appropriate for the social worker to be embedded in or work closely with, a team, which has access to ‘real time’ gang intelligence in order to undertake a reliable assessment.

Practitioners should be aware that children who are Looked After by the Local Authority can be particularly vulnerable to becoming involved in gangs. There may be a need to review their Care Plan in light of the assessment and to provide additional support.

Children may be in fear of ending their contact with the gang because it might leave them vulnerable to reprisals from those former gang members and rival gang members who may see the young person as without protection.

Sometimes if there is a possible “threat to life”, it may result in the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) issuing an Osman Warning. In these circumstances this should trigger an automatic referral by the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), the initiation of a Strategy Discussion and consideration of the need for immediate safeguarding action, unless to do so would place the child at greater risk.

In these cases, the decision not to refer should be actively reviewed to allow a referral to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) to be made at an appropriate stage in order to protect the young person’s safety.

Information and local knowledge about the specific gang should be shared, including the use, or suspected use, of weapons or drug dealing. There should also be consideration of possible risk to members of the child’s family and other children in the community.

Unless there are indications that parental involvement would risk further [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child, parents should be involved as early as possible where there are concerns about gang activity.

**Gang Injunctions**

“Gang injunctions offer local partners a way to intervene and to engage a young person aged 14-17 with positive activities, with the aim of preventing further involvement in gangs, violence and/or gang-related drug dealing activity”. (Home Office, June 2015)

The Serious Crime Act 2015) has amended the Crime and Security Act 2010 to extend this provision from 18 years and to include children and young people (14-17 year olds). it also now covers drug dealing activity” as well as “violence” including the threat of violence. Applications should focus on gang related behaviour that may lead to violence, and not other problematic antisocial behaviour.

In order to make a gang injunction, the court must be satisfied that the respondent has engaged in, encouraged or assisted gang-related violence or drug dealing activity. In addition, the court must then be satisfied that:

* The gang injunction is necessary to prevent the respondent from engaging in, encouraging or assisting gang-related violence or drug dealing activity; and/or
* The gang injunction is necessary to protect the respondent from gang related violence or drug taking activity.

**5. Issues**

Children involved in gangs are very likely to be previously known to other services for offending behaviour or school exclusion.

Common issues faced by girls and young women affected by sexual violence by gangs include domestic violence, drug and alcohol misuse, school exclusion and going missing from home.

Children may often be at the periphery of involvement for some time before they become active gang members. Children may also follow older siblings into gang involvement. There are often opportunities for preventative work to be undertaken with children.

**Honour based violence**

**1. Definition**

Honour based violence is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code.

For young victims it is a form of child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and a serious [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of human rights.

It can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members. Women, men and younger members of the family can all be involved in the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

**2. Risks**

Young victims may find themselves in an abusive and dangerous situation against their will with no power to seek help. The usual avenues for seeking help – through parents or other family members may be unavailable. Honour based violence manifests itself in a diverse range of ways with children and young people, including forced marriage, domestic and/or sexual violence, rape, physical assaults, harassment, kidnap, threats of violence (including murder), witnessing violence directed towards a sibling or indeed another family member, and female genital mutilation.

Female genital mutilation is an offence under the Female Genital Mutilation Act 2003, and can result in severe physical and psychological injuries and even death. It is almost always restricted to female children and young people i.e. those under 18 years old. See [Female Genital Mutilation Procedure](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2016/10/Practice-Guidance-for-practitioners-on-Female-Genital-Mutilation-2016-2.pdf).

Online targeting of victims is being used more frequently as a means of controlling and exploiting them.

Victims can find it difficult to leave abusive relationships or ask for help if their immigration status is uncertain. They may face a number of issues such as a fear of deportation, bringing ‘shame’ on their families, financial difficulties and homelessness, or losing their children.

The notion of shame and the associated risk to the victim may persist long after the incident that brought about dishonour occurred. This means any new partner of the victim, children, associates or their siblings may be at serious risk of Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

Behaviours that could be seen to transgress concepts of honour include:

* Inappropriate make-up or dress;
* The existence of a boyfriend or a perceived unsuitable relationship e.g. a gay/lesbian relationship;
* Rejecting a forced marriage;
* Pregnancy outside of marriage;
* Being a victim of rape;
* Inter-faith relationships (or same faith, but different ethnicity);
* Leaving a spouse or seeking divorce;
* Kissing or intimacy in a public place;
* Alcohol and drugs use.

It is important to be mindful that young people may be subject to honour based violence for reasons which may seem improbable or relatively minor to others.

**3. Indicators**

It is likely that awareness that a child is the victim of an honour based crime will only come to light after an assault of some kind has taken place e.g. an allegation of [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/) or it may be that a child is reported as missing. There are inherent risks to the act of disclosure for the victim and possibly limited opportunities to ask for help for fear of retribution from their family or community.

There may be [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/), including controlling, coercive and dominating behaviour towards the victim. Self-harming, family disputes, and unreasonable restrictions on the young person such as removal from education or virtual imprisonment within the home may occur.

Young people may be fearful of being forced into engagement/marriage.

Other warning signs may be FGM, sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and forced marriage. (See [Female Genital Mutilation Procedure](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2016/10/Practice-Guidance-for-practitioners-on-Female-Genital-Mutilation-2016-2.pdf) and [Forced Marriage Procedure](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/forcedmarriage/)).

Continual assessment and review is paramount as circumstances can change very quickly, for example, following disclosure to the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) the risks to the victim and others who are supporting the victim may increase.

Young people may face significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) if their families/communities realise that they have asked for help. All aspects of their safety need to be carefully assessed at every stage. Initially this needs to address whether it is safe for them to return home following a disclosure. The young person will need practical help such as accommodation and financial support, as well as emotional support and information about their rights and choices.

Some families go to considerable lengths to find their children who run away, and young people who leave home are at risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) if they are returned to their family. They may be reported as missing by their families, but no mention is made of the reason. It is important that practitioners explore the underlying reasons before any decisions are made.

**4. Protection and Action to be Taken**

Any suspicion or disclosure of violence or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) against a child in the name of honour should be treated equally seriously as any other suspicion or disclosure or significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) against a child. However, there are significant differences in the immediate response required. Bearing in mind the specific practice issues set out, where the concerns about the welfare and safety of the child or young person are such that a referral to Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)should be made using [Cambridgeshire’s Making Referrals to the MASH](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/referralstomash/) and [Peterborough’s Making Referrals to Children Social Care](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/making-referrals-to-childrens-social-care/) procedures should be followed.

Involving families in cases of forced marriage is dangerous:

* It may increase the risk of serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the victim. Experience shows that the family may punish them for seeking help;
* Involving the family includes visiting the family to ask them whether they are intending to force their child to marry or writing a letter to the family requesting a meeting about their child’s allegation that they are being forced to marry;
* Interpreters should be on the approved list. Relatives, friends, community leaders and neighbours should not be used as interpreters in case they are linked to the group suspected of carrying out the crime – despite any reassurances from this known person.

In cases of violence in the name of honour and of forced marriage, it is essential to consider other siblings in the family that may be experiencing, or at risk of, the same [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

Accurate record keeping in all cases of violence/[abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) in the name of honour is important. Records should:

* Be accurate, detailed, clear and include the date;
* Use the person’s own words in quotation marks;
* Document any injuries – include photographs, body maps or pictures of their injuries;
* Only be available to those directly involved in the person’s case.

Practitioners must take care that information which increases the risk to the child is not inadvertently shared with family members.

**5. Issues**

Addressing the needs of the individual is key, as victims of honour-based violence will require a tailored response dependent on a number of factors including e.g. language and cultural barriers, how long they have been in the country, their social and family networks and their economic circumstances.

**The ‘One Chance Rule’**

All practitioners working with victims of honour based violence need to be aware of the ‘one chance’ rule. That is, they may only have one chance to speak to a potential victim and thus they may only have one chance to save a life. This means that all practitioners working within statutory agencies need to be aware of their responsibilities and obligations when they come across these cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted.

**6. Further Information**

[Forced Marriage](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/forcedmarriage/)

[Female Genital Mutilation](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2016/10/Practice-Guidance-for-practitioners-on-Female-Genital-Mutilation-2016-2.pdf)

[Trafficked Children](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/safeguarding-children-who-may-have-been-trafficked/)

[Forced Marriage Guidance, Home Office](https://www.gov.uk/guidance/forced-marriage) – information and practice guidelines for professional protecting, advising and supporting victims

[Legal Guidance](http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/)– not specifically about children

[Forced Marriage and Honour Based Violence Screening Toolkit](http://www.resolution.org.uk/site_content_files/files/forcedmarriage_toolkit_layout_1.pdf)

[SafeLives Dash Risk Checklist for the Identification of High Risk Cases of Domestic Abuse, Stalking and ‘Honour’-based Violence](http://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL.pdf)

[Ending Violence against Women and Girls (VAWG) Strategy: 2016 to 2020](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF)

[Protocol on the handling of ‘so-called’ Honour Based Violence/Abuse and Forced Marriage Offences between the National Police Chiefs’ Council and the Crown Prosecution Service](http://www.cps.gov.uk/publications/agencies/HBV_and_FM_Protocol.pdf)

**Hostile parents**

**1. Introduction**

There can be a wide range of uncooperative behaviour by families towards professionals.  From time to time agencies will come into contact with families whose compliance is apparent rather than genuine, or who are more obviously reluctant or sometimes angry or hostile to their approaches.

In extreme cases, professionals can experience intimidation, [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), threats violence and actual violence.  The child’s welfare should remain paramount at all times and where professionals are too scared to confront the family, they must also consider what life is like for a child in the family.

All agencies should support their staff by:

* Ensuring professionals are trained for the level of work they are undertaking;
* Publishing a clear statement about unacceptable behaviour by those accessing their services (such as seen in hospitals and on public transport);
* Providing training to enable staff to respond as safely as possible to risky or hostile behaviour in their target client group;
* Supporting staff to work to their own professional code of conduct or their agency’s code of conduct when responding to risky or hostile behaviour in their client group.

**2. Definition**

There are four types of uncooperativeness:

* **Ambivalence:** can be seen when people are always late for appointments, or repeatedly make excuses for missing them; when they change the conversation away from uncomfortable topics and when they use dismissive body language. Ambivalence is the most common reaction and may not amount to uncooperativeness. All service users are ambivalent at some stage in the helping process which is related to the dependence involved in being helped by others. It may reflect cultural differences, being unclear what is expected, or poor experiences of previous involvement with professionals. Ambivalence may need to be acknowledged, but it can be worked through;
* **Avoidance:** a very common method of uncooperativeness, including avoiding appointments, missing meetings, and cutting visits short due to other apparently important activity (often because the prospect of involvement makes the person anxious and they hope to escape it). They may have difficulty, have something to hide, resent outside interference or find staff changes another painful loss. They may face up to the contact as they realise the professional is resolute in their intention, and may become more able to engage as they perceive the professional’s concern for them and their wish to help;
* **Confrontation:** includes challenging professionals, provoking arguments, extreme avoidance (e.g. not answering the door as opposed to not being in) and often indicates a deep-seated lack of trust leading to a ‘fight’ rather than ‘flight’ response to difficult situations. Parents may fear, perhaps realistically, that their children may be taken away or may be reacting to them having been taken away. They may have difficulty in consistently seeing the professional’s good intent and be suspicious of their motives. It is important for the professional to be clear about their role and purpose, demonstrate a concern to help, but not to expect an open relationship to begin with.  However, the parent’s uncooperativeness must be challenged, so they become aware the professional / agency will not give up.  This may require the professionals to cope with numerous displays of confrontation and aggression until eventual co-operation may be achieved;
* **Violence:** threatened or actual violence by a small minority of people is the most difficult of uncooperative behaviours for the professional / agency to engage with. It may reflect a deep and longstanding fear and projected hatred of authority figures. People may have experience of getting their way through intimidation and violent behaviour. The professional / agency should be realistic about the child or parent’s capacity for change in the context of an offer of help with the areas that need to be addressed.

**3. Impact on Assessment**

Accurate information and a clear understanding of what is happening to a child within their family and community are vital to any assessment. The usual and most effective way to achieve this is by engaging parents and children in the process of assessment, reaching a shared view of what needs to change and what support is needed, and jointly planning the next steps.

Engaging with a parent who is resistant or even violent and / or intimidating is more difficult. The behaviour may be deliberately used to keep professionals from engaging with the parent or child, or can have the effect of keeping professionals at bay. There may be practical restrictions to the ordinary tools of assessment (e.g. seeing the child on their own, observing the child in their own home etc). The usual sources of information / alternative perceptions from other professionals and other family members may not be available because no-one can get close enough to the family.

Professionals from all agencies should explicitly identify and record what area of assessment are difficult to achieve and why, and record what plan of action is to be taken.

The presence of violence or intimidation needs to be included in any assessment of risk to the child living in such an environment.

**3.1 Impact on assessment of the child**

The professional needs to be mindful of the impact the hostility to outsiders may be having on the day-to-day life of the child.

Professionals in all agencies should consider:

* Whether the child is keeping ‘safe’ by not telling professionals things;
* Whether the child has learned to appease and minimise;
* Whether the child is blaming himself or herself;
* What message the family is getting if the professional / agency does not challenge the parent(s).

**3.2 Impact on assessment of the adults**

In order to assess to what extent the hostility of the parent(s) is impacting on the assessment of the child, professionals in all agencies should consider whether they are:

* Colluding with the parent(s) by avoiding conflict;
* Filtering out or minimising negative information;
* Conversely, placing undue weight on positive information (the ‘rule of optimism’) and only looking for positive information;
* Keeping quiet about worries and not sharing information about risk and assessment with others in the inter-agency network or with managers.
* Focusing on the parent’s needs, not the child’s;
* Not asking to see the child alone;

Professionals and their supervisors should keep asking themselves the question: what might the children have been feeling as the door closes behind a professional leaving the family home?

**4. Impact on Multi Agency Work**

Sometimes parents may be hostile to specific agencies or individuals.  If the hostility is not universal, then agencies should seek to understand why this might be and learn from each other. The risks are of splitting between the professionals / agencies, with tensions and disagreement taking the focus from the child.

Where hostility towards most agencies is experienced, this needs to be managed on an inter-agency basis otherwise the results can be as follows:

* Everyone ‘backs off’, leaving the child unprotected;
* The family is ‘punished’ by withholding of services as everyone ‘sees it as a fight’, at the expense of assessing and resolving the situation for the child;
* There is a divide between those who want to appease and those who want to oppose – or everyone colludes.

**4.1 Ensuring effective multi-agency working**

Any professional or agency faced with incidents of threats, hostility or violence should routinely consider the potential implications for any other professional or agency involved with the family in addition to the implications for themselves and should alert to the nature of the risks.  Information sharing is crucial to protect professionals and children

**4.2 Sharing information**

There are reasonable uncertainties and need for care when considering disclosing personal information about an adult.

Concerns about the repercussions from someone who can be hostile and intimidating can become an added deterrent to sharing information. However, information sharing is pivotal, and also being explicit about experiences of confronting hostility / intimidation or violence should be standard practice.

**5. Supervision and support**

Each agency should have a supervisory system in place that is accessible to the professional and reflects practice needs. Supervision discussions should focus on any hostility being experienced by professionals or anticipated by them in working with families and should address the impact on the professional and the impact on the work with the family.

Managers should encourage a culture of openness, where their professionals are aware of the support available within the team and aware of the welfare services available to them within their agency. Managers must ensure that staff members feel comfortable in asking for this support when they need it. This includes ensuring a culture that accepts no intimidation or bullying from service users or colleagues. A ‘buddy’ system within teams may be considered as a way of supporting professionals.

Professionals must feel safe to admit their concerns knowing that these will be taken seriously and acted upon without reflecting negatively on their ability or professionalism.

Discussion in supervision should examine whether the behaviour of the service user is preventing work being effectively carried out. It should focus on the risk factors for the child within a hostile or violent family and on the effects on the child of living in that hostile or aggressive environment.

An agreed action plan should be drawn up detailing how any identified risk can be managed or reduced. This should be clearly recorded in the supervision notes. The action plan should be agreed prior to a visit taking place.

The professional should prepare for supervision and bring case records relating to any violence / threats made. They should also be prepared to explore ‘uneasy’ feelings, even where no overt threats have been made. Managers will not know about the concerns unless the professional reports them. By the same token, managers should be aware of the high incidence of under reporting of threats of violence and should encourage discussion of this as a potential problem.

Health and safety should be a regular item on the agenda of team meetings and supervisions. In addition, group supervision or team discussions can be particularly useful to share the problem and debate options and responsibilities.

Files and computer records should clearly indicate the risks to professionals, and mechanisms to alert other colleagues to potential risks should be clearly visible on case files.

**5.1 Multi-agency meetings**

Working with hostile and uncooperative parents is complex and for meetings to be successful the following questions should be considered:

* Discussing with the chair the option of excluding the parents if the quality of information shared is likely to be impaired by the presents of threatening adults;
* Convening a meeting of the agencies involved to share concerns, information and strategies and draw up an effective work plan that clearly shares decision-making and responsibilities. If such meetings are held, there must always be an explicit plan made of what, how and when to share what has gone on with the family.  Confidential discussions are to remain secret and there are legal obligations to consider in any event (e.g. Data Protection Act 1998 – see Information Sharing and Confidentiality), and the aim should always be to empower professionals to become more able to be direct and assertive with the family without compromising their own safety;
* Convening a meeting to draw up an explicit risk reduction plan for professionals and in extreme situations, instituting repeat meetings explicitly to review the risks to professionals and to put strategies in place to reduce these risks:
* Joint visits with [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), colleagues or professionals from other agencies:
* Debriefing with other agencies when professionals have experienced a frightening event.

Although working with hostile families can be particularly challenging, the safety of the child is the first concern.  If professionals are too scared to confront the family, consider what life is like for the child.

**6. Response to Uncooperative Families**

When a professional begins to work with a family who is known, or discovered, to be uncooperative, the professional should make every effort to understand why a family may be uncooperative or hostile. This entails considering all available information, including whether a common assessment has been completed and whether a lead professional has been appointed.

When working with uncooperative parents, professionals in all agencies can improve the chances of a favourable outcome for the child/ren by:

* Keeping the relationship formal though warm, giving clear indications that the aim of the work is to achieve the best for their child/ren;
* Clearly stating their professional and/or legal authority;
* Continuously assessing the motivations and capacities of the parent/s to respond co-operatively in the interests of their child/ren;
* Confronting uncooperativeness when it arises, in the context of improving the chances of a favourable outcome for the child/ren;
* Engaging with regular supervision from their manager to ensure that progress with the family is being made and is appropriate;
* Seeking advice from experts (e.g. [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), mental health specialists) to ensure progress with the family is appropriate;
* Helping the parent to work through their underlying feelings at the same time as supporting them to engage in the tasks of responsible child care;
* Being alert to underlying complete resistance (possibly masked by superficial compliance) despite every effort being made to understand and engage the parent/s;
* Being willing, in such cases, to take appropriate action to protect the child/ren (despite this action giving rise to a feeling of personal failure by the professional in their task of engaging the parent/s).

**6.1 Respecting families**

Families may develop increased resistance or hostility to involvement if they perceive the professional as disrespectful and unreliable or if they believe confidentiality has been breached outside the agreed parameters.

Professionals should be aware that some families, including those recently arrived from abroad, may be unclear about why they have been asked to attend a meeting, why the professional wants to see them in the office or to visit them at home.  They may not be aware of roles that different professionals and agencies play and may not be aware that the local authority and partner agencies have a statutory role in safeguarding children, which in some circumstances override the role and rights of parents (e.g. child protection).

Professionals should seek expert help and advice in gaining a better understanding, when there is a possibility that cultural factors are making a family resistant to having professionals involved. Professionals should be:

* Aware of dates of the key religious events and customs;
* Aware of the cultural implications of gender;
* Acknowledge cultural sensitivities and taboos e.g. dress codes.
* Professionals may consider asking for advice from local experts, who have links with the culture. In such discussions the confidentiality of the family concerned must be respected.

Professionals who anticipate difficulties in engaging with a family may want to consider the possibility of having contact with the family jointly with another person in whom the family has confidence.  Any negotiations about such an arrangement must be underpinned by the need for confidentiality in consultation with the family.

Professionals need to ensure that parents understand what is required of them and the consequences of not fulfilling these requirements, throughout. Professionals must consider whether:

* A parent has a low level of literacy, and needs verbal rather than written communication;
* A parent needs translation and interpretation of all or some communication into their own language;
* It would be helpful to a parent to end each contact with a brief summary of what the purpose has been, what has been done, what is required by whom and by when.
* The parent is aware that relevant information / verbal exchange is recorded and that they can access written records about them.

**7. Dealing with Hostility and Violence**

Despite sensitive approaches by professionals, some families may respond with hostility and sometimes this can lead to threats of violence and actual violence.

It is critical both for the professional’s personal safety and that of the child that risks are accurately assessed and managed.

Threats can be covert or implied (e.g. discussion of harming someone else), as well as obvious.  In order to make sense of what is going on in any uncomfortable exchange with a parent, it is important that professional are aware of the skills and strategies that may help in difficult and potentially violent situations.

**7.1 Making sense of hostile responses**

Professionals should consider whether:

* They are prepared that the response from the family may be angry or hostile. They should ensure they have discussed this with their manager and planned strategies to use if there is a predictable threat (e.g. an initial visit with [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) to establish authority):
* They might have aggravated the situation by becoming angry or acting in a way that could be construed as being patronising or dismissive.
* The hostility is a response to frustration, either related or unrelated to the professional visit;
* The parent needs to complain, possibly with reason;
* The parent’s behaviour is deliberately threatening / obstructive / abusive or violent;
* The parent is aware of the impact they are having on the professional;
* They are so used to aggression, they do not appreciate the impact of their behaviour;
* This behaviour is normal for this person (which nevertheless does not make it acceptable);
* The professional’s discomfort is disproportionate to what has been said or done;
* The professional is taking this personally in a situation where hostility is aimed at the agency.

**7.2 Impact on professionals of hostility and violence**

Working with potentially hostile and violent families can place professionals under a great deal of stress and can have physical, emotional and psychological consequences, which may impact on their capacity to make effective decisions.

**7.3 Keeping professionals safe**

Professionals have a responsibility to plan for their own safety, just as the agency has the responsibility for trying to ensure their safety. Professionals should consult with their line manager to draw up plans and strategies to protect their own safety and that of other colleagues. There should be clear protocols for information sharing (both internal and external). Agencies should ensure that staff and managers are aware of where further advice can be found.

If threats and violence have become a significant issue for a professional, the line manager should consider how the work could safely be progressed, document their decision and the reason for it.

Awareness that threat of violence constitute a criminal offence and the agency must take action on behalf of staff (i.e. make a complaint to the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)).

Managers have a statutory duty to provide a safe and working environment for their employees under the Health and Safety at Work legislation.

**Information sharing**

**Introduction**

Sharing information is vital for early intervention to ensure that children with additional needs receive the services they require. It is also essential to protect children from suffering Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

There is a positive duty under the Human Rights Act 1998 to protect life (Article 2 of the European Convention on Human Rights) and to protect others from inhuman and degrading treatment (Article 3 of the European Convention of Human Rights). All public authorities must ensure that everything they do promotes these rights and, in circumstances where a child has suffered or is likely to suffer Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), this includes the sharing of information with others so that the child’s human rights can be protected.

Practitioners are sometimes uncertain about when they can share information lawfully. It is important therefore that they:

* Understand and apply good practice in sharing information at an early stage as part of preventative work;
* Understand what information is and is not confidential, and the need in some circumstances to make a judgement about whether confidential information can be shared, in the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/), without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/);
* Understand what to do when they have reasonable cause to believe that a child may be suffering, or may be at risk of suffering, Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and are clear of the circumstances when information can be shared where they judge that a child is at risk of Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* Understand what to do when they have reasonable cause to believe that an adult may be suffering, or may be at risk of suffering, serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and are clear of the circumstances when information can be shared where they judge that an adult is at risk of serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* Are supported by their employer in working through these issues.

Staff in adults’ services are aware that problems faced by those with responsibilities as parents are often likely to affect children and other family members. However this information is not always shared and opportunities to put preventative support in place for the children and the family are missed. Where an adult receiving services is a parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/), sharing information with colleagues in children’s services could ensure that any additional support required for their children can be provided early.

You do not need [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to share personal information. It is one way to comply with the data protection legislation but not the only way. This is explored more in the next section of this chapter.

**The Concept of Information Sharing & The General Data Protection Regulation (GDPR) and Data Protection Act 2018**

Working Together to Safeguard Children 2018 states that:

“Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe. Serious case reviews (now referred to as child safeguarding practice reviews) have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children.

“Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) (e.g. they are being supported as a child in need or have a child protection plan). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child’s safety or welfare.”

Information sharing is also essential for the identification of patterns of behaviour when a child is at risk of going missing or has gone missing, when multiple children appear associated to the same context or locations of risk, or in relation to children in the secure estate where there may be multiple local authorities involved in a child’s care. It will be for local safeguarding partners to consider how they will build positive relationships with other local areas to ensure that relevant information is shared in a timely and proportionate way.

The Data Protection Act 2018 and General Data Protection Regulations (GDPR) do not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe. Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children.

For more information see: [Working Together to Safeguard Children 2018 – page 21 – Myth-busting guide to information sharing](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf#page=21)

**Key Points for Workers when Sharing Information**

Professionals do not necessarily need the [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) of the information subject to share their personal information.

Wherever possible, you should seek [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) and be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared. You should seek [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) where an individual may not expect their information to be passed on. When you gain [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to share information, it must be explicit, and freely given.

There may be some circumstances where it is not appropriate to seek [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), either because the individual cannot give [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), it is not reasonable to obtain [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), or because to gain [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) would put a child or young person’s safety or well-being at risk.

Where a decision to share information without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) is made, a record of what has been shared should be kept. The general principle is that information will only be shared with the [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) of the subject of the information.

Sharing confidential information without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) will normally be justified in the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) in the circumstances shown below in Confidentiality and [Consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/).

**The Seven Golden Rules for Information Sharing**

1. Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Where possible, share information with [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), and where possible, respect the wishes of those who do not [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and upto-date, is shared in a timely fashion, and is shared securely (see principles).
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Source: Information sharing: advice for practitioners providing safeguarding services (July 2018).

The ‘Seven Golden Rules’ and the following Questions will help support your decision making so you can be more confident that information is being shared legally and professionally. Each situation should be considered on a case-by-case basis. See Information Sharing Flowchart

Diagram

Description automatically generated

If you answer ‘not sure’ to any of the questions, seek advice from your supervisor, manager, nominated person within your organisation or area, or from a [professional body](https://www.safeguardingcambspeterborough.org.uk/glossary/professional-body/).

The Information sharing guidance for Practitioners makes a point which should be borne in mind. Information can be held in many different ways, in case records or electronically in a variety of IT systems with access for different professionals. The use of emails in professional communications also raises another mechanism for sharing information other than in direct person to person contact. However the information is shared, it should always be recorded in the individual’s record.

**Confidentiality and Consent**

Working Together 2018 states that:

Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). To share information effectively:

* all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for safeguarding purposes, including information which is sensitive and personal, and should be treated as ‘special category personal data’
* where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 contains ‘safeguarding of children and individuals at risk’ as a processing condition that allows practitioners to share information. This includes allowing practitioners to share information without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), if it is not possible to gain [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), it cannot be reasonably expected that a practitioner gains [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), or if to gain [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) would place a child at risk.

It is also possible that an overriding [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) would justify disclosure of the information (or that sharing is required by a court order, other legal obligation or statutory exemption). To overcome the common law duty of confidence, the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) threshold is not necessarily difficult to meet – particularly in emergency situations. Confidential health information carries a higher threshold, but it should still be possible to proceed where the circumstances are serious enough. As is the case for all personal information processing, initial thought needs to be given as to whether the objective can be achieved by limiting the amount of information shared – does all of the personal information need to be shared to achieve the objective?

A Myth Busting Guide to information sharing is avaliable.

**Caldicott Guardians**

A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the NHS, Local Authority Social Services Departments and partner organisations satisfy the highest practicable standards for handling patient identifiable information.

**The Eight Caldicott Principles**

1. Justify the purpose(s) for using confidential information;
2. Don’t use personal confidential data unless it is absolutely necessary;
3. Use the minimum necessary personal confidential data;
4. Access to personal confidential data should be on a strict need-to-know basis;
5. Everyone with access to personal confidential data should be aware of their responsibilities;
6. Comply with the law;
7. The duty to share information can be as important as the duty to protect patient confidentiality
8. Inform patients and service users about how their confidential information is used

See more here – [Eight Caldicott Principles 08.12.20.pdf (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942217/Eight_Caldicott_Principles_08.12.20.pdf)

Every local Health Service and Children and Young People’s Directorate has its own Caldicott Guardian, to provide advice and guidance on appropriate information sharing.

**National Guidance on Sharing Information**

Working Together 2018 states that:

* all organisations and agencies should have arrangements in place that set out clearly the processes and the principles for sharing information. The arrangement should cover how information will be shared within their own organisation/agency; and with others who may be involved in a child’s life.
* all practitioners should not assume that someone else will pass on information that they think may be critical to keeping a child safe. If a practitioner has concerns about a child’s welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), then they should share the information with local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and/or the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/). All practitioners should be particularly alert to the importance of sharing information when a child moves from one local authority into another, due to the risk that knowledge pertinent to keeping a child safe could be lost
* all practitioners should aim to gain [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to share information, but should be mindful of situations where to do so would place a child at increased risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). Information may be shared without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) if a practitioner has reason to believe that there is good reason to do so, and that the sharing of information will enhance the safeguarding of a child in a timely manner. When decisions are made to share or withhold information, practitioners should record who has been given the information and why

Where there is a clear risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to a child, or serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to adults, the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/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. 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.

The relevant issues for social workers are usually around sharing information where [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) has been withheld. There is a [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) defence if sharing information is for the purposes of safeguarding a child or vulnerable person.

Section 115 of the Crime and Disorder Act 1998 establishes:

The power to disclose information is central to the Act’s partnership approach. The [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) have an important general power under common law to disclose information for the prevention, detection and reduction of crime. However, some other public bodies that collect information may not previously have had power to disclose it to the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and others. This section puts beyond doubt the power of any organisation to disclose information to [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) authorities, local authorities, Probation Service, Health Authorities, or to persons acting on their behalf, so long as such disclosure is necessary or expedient for the purposes of crime prevention. These bodies also have the power to use this information.

Article 8 in the European Convention on Human Rights states that:

Everyone has the right to respect for his/her private and family life, home and correspondence;

There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of rights and freedoms of others.

**The Domestic Violence Disclosure Scheme**

The Domestic Violence Disclosure Scheme (DVDS), also known as “Clare’s Law” enables the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) to disclose information to a victim or potential victim of [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/) about their partner’s or ex-partner’s previous abusive or violent offending. This scheme adds a further dimension to the information sharing about children where there are concerns that domestic violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is impacting on the care and welfare of the children in the family.

Members of the public can make an application for a disclosure, known as the ‘right to ask’. Anybody can make an enquiry, but information will only be given to someone at risk or a person in a position to safeguard the victim. The scheme is for anyone in an intimate relationship regardless of gender.

Partner agencies can also request disclosure is made of an offender’s past history where it is believed someone is at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). This is known as ‘right to know’.

If a potentially violent individual is identified as having convictions for violent offences, or information is held about their behaviour which reasonably leads the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and other agencies to believe they pose a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to their partner, a disclosure will be made.

A disclosure can be made lawfully by the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) under the scheme if the disclosure is based on the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)’s common law powers to disclose information where it is necessary to prevent crime, and if the disclosure also complies with established case law, as well as data protection and human rights legislation. It must be reasonable and proportionate for the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) to make the disclosure, based on a credible risk of violence or [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

**Child Sex Offender Disclosure Scheme**

The Child Sex Offender Disclosure Scheme (CSOD) is designed to provide members of the public with a formal mechanism to ask for disclosure about people they are concerned about, who have unsupervised access to children and may therefore pose a risk. This scheme builds on existing, well established third-party disclosures that operate under the Multi-Agency Public Protection Arrangements (MAPPA).

[Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) will reveal details confidentially to the person most able to protect the child (usually parents, carers or guardians) if they think it is in the child’s interests.

The scheme has been operating in all 43 [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) areas in England and Wales since 2010. The scheme is managed by the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and information can only be accessed through direct application to them.

If a disclosure is made, the information must be kept confidential and only used to keep the child in question safe. Legal action may be taken if confidentiality is breached. A disclosure is delivered in person (as opposed to in writing) with the following warning:

* ‘That the information must only be used for the purpose for which it has been shared i.e. in order to safeguard children;
* The person to whom the disclosure is made will be asked to sign an undertaking that they agree that the information is confidential and they will not disclose this information further;
* A warning should be given that legal proceedings could result if this confidentiality is breached. This should be explained to the person and they must sign the undertaking’ (Home Office, 2011, p16).

If the person is unwilling to sign the undertaking, the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) must consider whether the disclosure should still take place.

**Age Assessment Information Sharing for Unaccompanied Asylum Seeking Children**

The issue of age assessment in social work with asylum seeking young people remains controversial and has been something that Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)have struggled with since the millennium. The ADCS Asylum Task Force has worked with the Home Office to provide two new jointly agreed documents, as detailed below. These documents are offered as practice guidance, by way of assistance to local authorities and their partners. The use of the proforma and [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) form is voluntary. The content does not, nor does it seek to, be binding on local authorities. It is simply a recommended approach.

See also:

* [Introduction to Joint Working Guidance](https://adcs.org.uk/assets/documentation/Introductory_note_to_Age_Assessment_Joint_Working_Guidance_final.pdf)
* [Joint Working Guidance](https://adcs.org.uk/assets/documentation/age_assessment_joint_working_guidance_april_2015.pdf)
* [Age Assessment Guidance](https://adcs.org.uk/assets/documentation/Age_Assessment_Guidance_2015_Final.pdf)
* [Age Assessment Information Sharing for Unaccompanied Asylum Seeking children: Explanation and Guidance](https://adcs.org.uk/assets/documentation/ADCS_HO_Age_Assessment_Information_Sharing_for_Unaccompanied_Asylum_Seeking_Children_revised_April_2015_final.pdf)
* [Age Assessment Information Sharing Proforma](https://adcs.org.uk/assets/documentation/information_sharing_proforma_april_2015.doc)

**LADO**

**1. Introduction and Criteria**

All allegations of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of children by those who work with children must be taken seriously. Allegations against any person who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

This procedure should be applied when there is such an allegation or concern 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;
* Behaved towards a child or children in a way that indicates he or she may pose a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to children.

These behaviours should be considered within the context of the four categories of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) (i.e. physical, sexual and emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people, for example:

* Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see ss16-19 [Sexual Offences Act 2003](http://www.legislation.gov.uk/ukpga/2003/42/contents));
* ‘Grooming’, i.e. meeting a child under 16 with intent to commit a relevant offence (see s15 [Sexual Offences Act 2003](http://www.legislation.gov.uk/ukpga/2003/42/contents));
* Other ‘grooming’ behaviour giving rise to concerns of a broader child protection nature (e.g. inappropriate text / e-mail messages or images, gifts, socialising etc);
* Possession of indecent photographs / pseudo-photographs of children.

If concerns arise about the person’s behaviour to her/his own children, the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and/or children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) must consider informing the employer / organisation in order to assess whether there may be implications for children with whom the person has contact at work / in the organisation, in which case this procedure will apply.

Allegations of historical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) should be responded to in the same way as contemporary concerns. In such cases, it is important to find out whether the person against whom the allegation is made is still working with children and if so, to inform the person’s current employer or voluntary organisation or refer their family for assessment.

All references in this document to ‘ staff or members of staff’ should be interpreted as meaning all paid or unpaid staff / professionals and volunteers, including for example foster carers, approved adopters and child minders. This chapter also applies to any person, who manages or facilitates access to an establishment where children are present.

**2. Roles and Responsibilities**

Working Together 2018 states:

County level and unitary local authorities should ensure that allegations against people who work with children are not dealt with in isolation. Any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a coordinated manner. Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of multi – agency arrangements or otherwise), to be involved in the management and oversight of allegations against people that work with children. Any such officer, or team of officers, should be qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay.

Local authorities should put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

Each Cambridgeshire and Peterborough LSCB member organisation should identify a named senior officer with overall responsibility for:

* Ensuring that the organisation deals with allegations in accordance with this Cambridgeshire & Peterborough LSCB procedure;
* Resolving any inter-agency issues;

Designated Officers (LADO) are responsible for the following:

* Receive reports about allegations and to be involved in the management and oversight of individual cases that meet the defined Threshold criteria;
* Provide advice and guidance to employers, including voluntary organisations;
* Liaise with the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/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;
* Provide advice and guidance to employers including voluntary organisations in relation to making referrals to the Disclosure and Barring Service (DBS) and regulatory bodies.

**3. General Considerations Relating to Allegations Against People who Work with Children**

**Persons to be notified**

The employer must inform the local authority designated officer (LADO) within one working day when an allegation is made and prior to any further investigation taking place.

**Local Authority Designated Officer team:**

* [LADO@cambridgeshire.gov.uk](mailto:LADO@cambridgeshire.gov.uk)
* [LADO@peterborough.gov.uk](mailto:LADO@peterborough.gov.uk)

**Telephone contacts:**

* 01223 727967 – Cambridgeshire
* 01733 864038 – Peterborough
* Out of Hours [Emergency Duty Team](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/): 0345 0455203 Cambridge, 01733 864180 Peterborough

The employer should seek advice from the LADO, the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and / or Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) about how much information might be disclosed to the accused person in the first instance, and this is further discussed at the Allegations Management Meeting.

The accused person who works with children should:

* Be treated fairly and honestly and helped to understand the concerns expressed and processes involved;
* Be kept informed of the progress and outcome of any investigation and the implications for any disciplinary or related process;
* If suspended, be kept up to date about events in the workplace.

The registered provider has a duty to inform Ofsted of all allegations made against any person employed to work with children in any registered setting such as foster [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/), prospective adopter, or person who works with children in a Residential Home; School; and day care facility including child minders. OFSTED will also be invited by LADO to take part in any subsequent strategy meeting/ Allegations Management Meeting.

**Confidentiality**

Confidentiality must be maintained and guard against publicity while an allegation is being investigated or considered. Apart from keeping the child, parents and accused person (where this would not place the child at further risk) up to date with progress of the case, information should be restricted to those who have a need to know in order to protect children, facilitate enquiries, manage related disciplinary or suitability processes.

**Support**

The organisation, together with Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and / or [police](https://www.safeguardingcambspeterborough.org.uk/glossary/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.

Employers have a duty of care for employees.

**Organised abuse**

Investigators should be alert to signs of organised or widespread [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/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](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) procedures which, if applicable, will take priority. See [Organised and Complex Abuse Procedure](http://www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/organised-and-complex-abuse/).

**Whistleblowing**

All staff should be made aware of the organisation’s whistle-blowing policy and feel confident to voice concerns about the attitude or actions of colleagues.

If a person who works with children believes that a reported allegation or concern is not being dealt with appropriately by their organisation, they should report the matter to the LADO.

**Timescales**

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 of 80% of cases to be concluded within 1 month is realistic in most cases.

**4. Employers Response to an Allegation or Concern**

An allegation against a person who works with children 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). It may also arise in the context of the person who works with children, and their life outside work, including at home.

**Initial action by person receiving or identifying an allegation or concern**

The person to whom an allegation or concern is first reported should treat the matter seriously and keep an open mind.

They 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.

They should:

* 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;
* Immediately report the matter to the designated senior manager, or the deputy in their absence or; where the designated senior manager is the subject of the allegation report to the deputy or other appropriate senior manager.

**Initial action by the designated senior manager**

When informed of a concern or allegation, the designated senior manager should not investigate the matter or interview the member of person who works with children, child concerned or potential witnesses.

They should:

* Obtain written details of the concern / allegation, signed and dated by the person receiving (not the child / adult making the allegation);
* Approve 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 person who works with children, any decisions made, and the reasons for those decisions.

The designated senior manager should report the allegation to the LADO and discuss the decision in relation to the agreed threshold criteria in [Section 1, Introduction and Criteria](http://cambridgeshirescb.proceduresonline.com/chapters/p_man_alleg.html#intro) within one working day. Referrals should not be delayed in order to gather information and a failure to report an allegation or concern in accordance with procedures is a potential disciplinary matter.

If an allegation requires immediate attention, but is received outside normal office hours, the designated senior manager should consult the Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) [emergency duty team](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/) or local [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and inform the LADO as soon as possible.

Similarly an allegation made to Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should be immediately reported to the LADO.

**5. Initial consideration by the designated senior manager and the LADO**

The LADO and Designated senior manager should consider first whether further details are needed. If there is clear [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) that the allegation is demonstrably false / unfounded or malicious, this will be documented and in the case of a malicious allegation, consideration given as to whether the matter should be referred to [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/).

The LADO will decide whether the case meets the threshold criteria for LADO involvement:

Working together 2018 stated that the 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
* Behaved towards a child or children in a way that indicates that they may pose a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to children

**6. LADO Allegation Management Meetings (AMM)**

When it has been agreed that a case meets the threshold criteria for LADO involvement, and there is no [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of the allegation being false/unfounded/ or malicious, the LADO will refer the matter to the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) for their consideration and advice as to whether the threshold for a criminal investigation is indicated.  Simultaneously the LADO will convene an Allegations Management Meeting (AMM), wherever possible within 3 working days.  The AMM will be chaired by the LADO and attended by the Named Senior Officer (or their nominated representative).

The purpose of the Initial and any Review AMM is to:

* Assess and manage the level and nature of any risk to children thought to be posed by the alleged perpetrator in any professional or voluntary capacity. Where there is a [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) investigation, this will always take precedence over disciplinary procedures.
* Fully assess the allegation and any other relevant information shared.
* Consider and ensure the effectiveness and sufficiency of safeguards in place to protect the child/ren involved and any other child/ren who may be affected.
* Consider need for any related section 47 enquiries
* Review and update decisions about information sharing with the alleged victim, parents/ carers and colleagues and the alleged perpetrator.
* Consider what support may be required for all parties.
* Ensure investigations are sufficiently independent
* Agree arrangements for reviewing investigations and monitoring progress, having regard to the target timescales
* Consider issues for the attention of senior management (e.g. media interest, resource implications);
* Consider whether a complex [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) investigation is applicable; (see Organised and Complex [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) Procedures)
* Plan enquiries if needed, allocate tasks and set timescales
* Referrals to Professional bodies/DBS/Panels
* Agree dates for future AMMs (In some cases it is necessary to hold Review AMMs to monitor the progress of cases to a managed conclusion).

At the conclusion of an investigation an AMM will be convened to share information and determine the outcome.  The outcome will be determined using one of the following definitions from Keeping Children Safe in Education 2018:

* Substantiated: there is sufficient [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to prove the allegation;
* Unsubstantiated: there is insufficient [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to either prove or disprove the allegation; the term therefore does not imply guilt or innocence.
* Malicious: there is sufficient [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to disprove the allegation and there has been a deliberate act to deceive;
* False: there is sufficient [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to disprove the allegation;
* Unfounded: To reflect cases where there is no [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) or proper basis which supports the allegation being made

Consideration will be given to action against person making the allegation, if found to be malicious.

**7. Record keeping and monitoring progress**

**Record keeping – Employers**

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.

The purpose of the record is to enable accurate information to be given in response to any future request for a reference if the person has moved on. It will provide clarification where a future DBS request reveals non convicted information, and will help to prevent unnecessary reinvestigation if an allegation re-surfaces after a period of time. In this sense it may serve as a protector to the individual themselves, as well as in cases where substantiated allegations need to be known about to safeguard future children.

Details of allegations that are found to be malicious should be removed from personnel records. For Education services see [Keeping Children Safe in Education: Statutory Guidance for Schools and Colleges](https://www.gov.uk/government/publications/keeping-children-safe-in-education--2).

**Monitoring progress – LADO**

The LADO should monitor and record the progress of each case. This could be by way of review Allegation Management Meeting / discussions and/or direct liaison with the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), or employer, as appropriate.

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 Cambridgeshire and Peterborough LSCB to monitor and evaluate the effectiveness of the procedures for managing allegations and provide statistical information to the [Department for Education (DfE)](http://www.education.gov.uk/) as required.

If a [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) investigation is to be conducted, the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) should set a date for reviewing its progress and consulting the CPS about continuing or closing the investigation or charging the individual. Wherever possible, this should be no later than four weeks after the strategy meeting / discussion / initial evaluation. Dates for further reviews should also be agreed, either fortnightly or monthly depending on the complexity of the investigation.

**8. Substantiated allegations and referral to the DBS**

**Who has a legal duty to refer?**

Regulated activity providers (employers or volunteer managers of people working in regulated activity in England, Wales and Northern Ireland) and personnel suppliers have a legal duty to refer to DBS where conditions are met. This applies even when a referral has also been made to a local authority safeguarding team or professional regulator.

You must make a referral when both of the following conditions have been met:

**Condition 1**

* you withdraw permission for a person to engage in regulated activity with children and/or vulnerable adults. Or you move the person to another area of work that isn’t regulated activity.

This includes situations when you would have taken the above action, but the person was re-deployed, resigned, retired, or left. For example, a teacher resigns when an allegation of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to a student is first made.

**Condition 2**

You think the person has carried out 1 of the following:

* engaged in relevant conduct in relation to children and/or adults. An action or inaction has harmed a child or vulnerable adult or put them at risk or [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or;
* satisfied the [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) test in relation to children and / or vulnerable adults. eg there has been no relevant conduct but a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to a child or vulnerable still exists.or
* been cautioned or convicted of a relevant (automatic barring either with or without the right to make representations ) offence

**9. Learning Lessons**

The employer and the LADO should review the circumstances of the case to determine whether there are any improvements to be made to the organisation’s procedures or practice.

**10. Procedures in specific organisations**

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 LADO.

**Identification of Individuals who Pose a Risk to Children**

**Posing a Risk to Children**

People convicted of an offence against a child that was listed in schedule 1 of the Children and Young Persons Act 1933 (i.e. sexual offence / violent offence on young people under the age of 18 / kidnap etc) used to be referred to as having ‘Schedule One Status’ – which remained on a person’s offending history for life..

In 2005 the Home Office produced guidance on replacing the term “Schedule 1 Offender” with the term “a person identified as presenting a risk, or potential risk, to children”.  This guidance included a list of offences that should act as a trigger to further assessment.  These offences can be found in [Home Office Circular 16/2005](https://webarchive.nationalarchives.gov.uk/20130126150516/http:/www.homeoffice.gov.uk/about-us/corporate-publications-strategy/home-office-circulars/circulars-2005/016-2005/). Any individual who commits any of these offences, or any offence where a child was involved, should be regarded as posing a potential risk to [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), with further assessment of this risk being necessary.  It should be noted that current behaviours of an individual should also be considered even when they have not committed one of the offences listed in the Home Office Guidance.

A worker in direct contact with such an individual, or a child where such an individual has a significant level of contact, needs to gain an understanding of how much risk, if any, they pose. Specialist agencies such as the Probation and Prison Service will assess this risk using their assessment tools, e.g.:

* Offender Assessment System (OASys) – a shared Prison Service and Probation Provider computer based assessment and planning tool designed for use with all offenders;
* Risk Matrix 2000 – a shared [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), Probation and Prison Service risk assessment tool for offenders who commit sexual and violent offences;
* ARMS, a more detailed and specific assessment tool shared by [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and Probation for offenders who commit sexual and violent offences;
* Spousal Assault Risk Assessment (SARA) – risk assessment tool used on domestic violence perpetrators by the Probation Provider and other agencies.

All these tools use a range of static criteria (e.g. age at first offence) and dynamic ones (e.g. level of substance misuse) to reach a judgement on risk. The planning process then looks to manage risk where appropriate and identify which are the key dynamic criteria that can be changed in a positive direction and reduce risk levels.

A worker from another agency should contact the Probation Provider to see if a relevant risk assessment has been undertaken. If not, they will need to form a judgement as to the risk posed on the basis of all information that can be reasonably obtained. This judgement will include [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of a pattern of behaviour, similarity between the current context and the context of the offence/s, and the presence of any contextual factor such as isolation, stress, or substance misuse. Any [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of grooming behaviour would immediately increase the assessed level of risk.

In some circumstances, an individual might reasonably be regarded as posing a risk to children without a conviction. Where there have been a number of allegations from unconnected victims, or repeated acquittals, particularly for reasons of legal procedure or where the vulnerability of the victim might reduce their credibility as a witness would be examples. In these circumstances considerable care needs to be exercised but reasonable actions can be taken to protect children. Clear guidance is not possible given the complexity of this area. Workers should consult their line manager and record the assessment made, the [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) on which it is based and any actions agreed.

**2. Management of Individuals who Pose a Risk of Harm to Children**

Effective arrangement of risk has to be based in inter agency working. A number of agencies have responsibility for the supervision of such individuals. These include the Probation Provider, Prison Service, Youth Offending Teams and the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/). Staff in these agencies should ensure that they communicate all relevant information about the risk they pose, where they live and the children with whom they have contact to the relevant [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) agency.

The [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) agencies are responsible for assessing the information available to them and responding to protect children as required in line with these procedures.

All agencies have a responsibility to work together in this situation as in any other covered by the current legislation, [**Working Together to Safeguard Children (2018)**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf) and these procedures.

**3. Other Multi-Agency Arrangements**

There are a number of other arrangements that exist alongside the Child Protection process.

**3.1 MAPPA (Multi Agency Public Protection Arrangements)**

[**Multi Agency Public Protection Arrangements National Guidance**](https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=5682416&exp=e1):

* Individuals need to have committed an offence covered by the statutory criteria to be subject to MAPPA;
* Most individuals who have committed such an offence will not be assessed as posing sufficient risk, the nature of which requires either MAPPA Level 2 arrangements (management through the formal co-operation of two or more agencies) or MAPPA Level 3 arrangements (where they are identified as being posing an immediate risk of serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and where an unusual level of agency resource is required to manage that risk);
* Only a small minority of people who pose a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to children will be covered by MAPPA. Not all MAPPA offenders pose any risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to children;
* MAPPA will be involved with an individual who presents a risk for as long as it is assessed as being necessary. This may over time involve a number of potential or real victims;
* MAPPA is designed to protect the public/potential victims from the [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) that could be caused by the registered MAPPA nominal.  Any other risks identified will be passed to the relevant organisations (eg the Probation Provider, [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), Children’s [Social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) etc).  .

**3.2 MARAC (Multi Agency Risk Assessment Conference)**

A MARAC will respond to situations where there is a high risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) from domestic violence. It will co-ordinate services from a range of agencies as required by the situation. Child protection will frequently feature as a major element in the risk assessment of any given situation. It therefore provides a good forum to engage a wide range of agencies in protecting children as well as the other victims from domestic violence.

However, MARACs are designed to produce a speedy co-ordination of services to protect victims. A situation will be assessed and a plan agreed. Implementation of the plan is monitored at the next meeting. The case then leaves the MARAC arena. It seeks to provide a speedy response to a high risk situation but does not provide a service that continues until the safety of the child is ensured.

**4. Legal and other Mechanisms for Managing Risk**

Where an offender is subject to a community sentence or post release licence, the Probation Provider has a series of powers and responsibilities in managing an individual’s risk. These can be enhanced with additional Licence Conditions (eg Polygraph testing, GPS Tagging etc) for those released from custody or additional requirements on Community Orders (eg completion of Accredited Programmes, Exclusion from certain areas etc).

Frequently, people who pose a significant risk are not subject to statutory supervision from a criminal court sentence. In these situations, a number of legal mechanisms are available.

The key resources include:

* Sex Offender Register and Notification Orders;
* Sexual [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) Prevention Orders and Sexual Risk Orders;
* Disqualification Orders (disqualified from working with children);
* Criminal Records check with the [**Disclosure and Barring Service**](http://trixresources.proceduresonline.com/nat_key/keywords/dis_barring_service.html);
* Disclosure and Barring Service Barred Lists.

VISOR is a national database of registered sex offenders and other Level 2 and 3 MAPPA offenders some of whom who pose a risk of serious sexual or physical [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to children or others. It is managed by the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), National Probation and Prison services.

**5. Civil and Criminal Orders for the Management of Offenders who Pose a Risk to Children**

**Sex Offender Registration, Sex Offender Restraining Orders and Sex Offender Orders**

**Orders for Managing Sex Offenders**

**Notification Order (NO)**

A NO Is obtained at criminal court alongside a conviction for qualifying sexual offences. This puts people on the Sex Offender Register in the United Kingdom. It is also a method of getting sex offenders who offend abroad on the register in this country – if they come to live here. This order enforces them to register as a sex offender. Length of notification is dependent on the period of sentence – anyone who receives a custodial sentence of 30 months or more will be on the sex offender register for life. If this order is breached they will be arrested and taken back to Court which could lead to imprisonment.

**Sexual**[**Harm**](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)**Prevention Order (SHPO) Schedule 5 Anti-social Behaviour Crime and Policing Act 2014**

The Sexual [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) Prevention Order (SHPO) replaced the sexual offences prevention order (SOPO) and foreign travel order (FTO) and may be made in relation to a person who has been convicted of or cautioned for a sexual or violent offence (including equivalent offences committed overseas) and who poses a risk of sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the public.

* The SHPO may be made by a court on conviction for a sexual or violent offence, or by the magistrates’ court on application by the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) or NCA. A court may impose an order for the purposes of protecting the public in the UK and/or children or vulnerable adults abroad from sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* An order may prohibit the person from doing anything described in it – this includes preventing travel overseas. Any prohibition must be necessary for protecting the public in the UK from sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or, in relation to foreign travel, protecting children or vulnerable adults from sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* A SHPO will make the person subject to the notification requirements for registered sex offenders for the duration of the order (that is, it puts them on the ‘sex offenders’ register’), if they are not already;
* A SHPO lasts a minimum of five years and has no maximum duration, with the exception of any foreign travel restrictions which, if applicable, must be renewed after five years.

**Sexual Risk Order (SRO) Schedule 5 Anti-social Behaviour Crime and Policing Act 2014**

The Sexual Risk Order (SRO) replaced the risk of sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) order and may be made in relation to a person without a conviction for a sexual or violent offence (or any offence), but who poses a risk of sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

The SRO may be made by the magistrates’ court on application, by the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) or NCA, where an individual has done an act of a sexual nature and as a result poses a risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the public in the UK or adults or vulnerable children overseas. “Acts of a sexual nature” are not defined in legislation, and therefore will depend to a significant degree on the individual circumstances of the behaviour and its context.

* The term intentionally covers a broad range of behaviour. Such behaviour may, in other circumstances and contexts, have innocent intentions. It also covers acts that may not in themselves be sexual but which have a sexual motive and/or are intended to allow the perpetrator to move on to sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* A SRO may prohibit the person from doing anything described in it – this includes preventing travel overseas. Any prohibition must be necessary for protecting the public in the UK from sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or, in relation to foreign travel, protecting children or vulnerable adults from sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* An individual subject to a SRO is required to notify the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) of their name and home address within three days of the order being made, and also to notify any changes to this information within three days;
* A SRO lasts a minimum of two years and has no maximum duration, with the exception of any foreign travel restrictions which, if applicable, last for a maximum of five years (but may be renewed);
* As with the SHPO, breach of an order is a criminal offence punishable by a maximum of five years’ imprisonment. The criminal standard of proof continues to apply, the person concerned is able to appeal against the making of the order, and the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) or the person concerned are able to apply for the order to be varied, renewed or discharged.

A breach of SRO will make the person subject to FULL notification requirements.

**Disqualification Order (DO)**

Introduced by the Criminal Courts and Court Services Act 2000 – where young people may be liable to receive a Disqualification Order which prohibits them from working with children if they are convicted of specified sexual / violence offences against children and / or supplying class A drugs to a child. Criminal Courts can impose a DO where a young person receives a qualifying sentence or relevant order for an offence against a child or if they have a relevant offence and the Court considers it likely that the young person may commit another offence against a child. Breach of the order is a criminal offence and could result in custody.

**Sex Offender Register**

Individuals have to have a Notification Order to be on the Sex Offender Register. The sex offender register came into being in 1997. This requires that individuals who have a qualifying sexual offence and certain periods of sentence to register as a sex offender with the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) at a prescribed [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) Station. Individuals have to register within 3 days of conviction or caution (for an adult) or for a young person within 3 days of conviction or Reprimand / Final Warning. The period of registration depends on the sentence and the offence and is generally halved for young people (unless they receive a period of more than 30 months – then they will be on the register indefinitely). The Register requires individuals to register an address if they are to stay at the address for 7 days or more in any 12 month period. Should they move permanently they have 3 days to make notification. In relation to all foreign travel (outside the United Kingdom) if they go abroad then they must inform the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/). The Sex Offender Register is a record on the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) National Computer – which will say who they are / what they did and when (if at all) the registration expires.

**Sex Offender Legislation**

Sex Offenders Act 2003, came into being May 2004 that changed registration periods and made orders more preventative, reduced the amount of young offenders on the register, brought in new sexual offences especially around safeguarding children and young people.

Sex Offenders Act 2003 (Notification Requirements) (England and Wales) Regulations 2012 gives four new requirements which came into force on 13 August 2012 where sex offenders have to notify the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/):-

* Of all foreign travel (including travel outside of the UK of less than three days);
* Weekly, where they are not registered as regularly residing or staying at one place (that is, where a registered sex offender has no sole or main residence and instead must notify the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) of the place where he can regularly be found);
* Where they are living in a household with a child under the age of 18; and bank account and credit card details and notify information about their passports or other identity documents at each notification, tightening the rules so that sex offenders can no longer seek to avoid being on the register when they change their name.

**The Disclosure Scheme**

Across the UK is an opportunity for people who have children and who have new partners to approach the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) for an informed disclosure as to whether the new partner may pose a risk to them and / or to their children from violent or sexual offences). These disclosures can be with regards to convictions and / or [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) intelligence and is shared on a case by case basis.

**Other Police, Community and Custodial Orders (for all offences)**

* **For 10 – 17 Year olds:-**

[**Police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/): – Simple Youth Caution/Conditional Youth Caution/Community Resolution.

**Youth Offending Service are:-**

[**Police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/): Community Resolution/Youth Caution (YC)/Youth Conditional Caution (YCC) (The YC and YCC are supported by YOS and YCC’s are administered by seconded [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) officers in Peterborough Targeted Youth Support Service (TYSS) and Cambridgeshire YOS). YCC’s will have a period of interventions offered depending on the offence including work with [**Cambridgeshire Sexual Behaviour Service**](http://www.cambridgeshire.gov.uk/site/custom_scripts/fid/fid_details.aspx?ID=172092)**or Peterborough TYSS Sexual Harmful Behaviour (SHB) worker**.

**Youth Offending Service**: Referral Order, Youth Rehabilitation Order (can have a number of requirements, main ones are: Supervision Requirement, Activity Requirement, Curfew Requirement + 16 different requirements to choose from), Reparation Order. Detention and Training Order (Custodial sentence) up to 2 years. Section 90/91 or Section 226/228 are all Custodial sentences which would be given in a Crown Court for more serious offences for custodial sentences of more than 2 years.

* **For 18 and above (adults):-**

**Probation Services** are now delivered by both private and public organisations. The majority of offenders will be managed by a Community Rehabilitation Company (CRC), and the Cambridgeshire area is part of the **BeNCH** CRC, which covers Bedfordshire, Cambridgeshire, Hertfordshire and Northamptonshire and is owned by Sodexo. The public organisation is the **National Probation Service (NPS)**, and the Cambridgeshire and Peterborough Local Delivery Unit is part of the bigger South East and East Division. Most, but not all, sexual offenders will be subject to MAPPA arrangements, and all offenders subject to MAPPA are managed by the NPS. The NPS is also responsible for all interaction with the criminal courts, be it providing reports for courts at sentencing stage or dealing with enforcement.

Offenders are supervised by probation services under the terms of a community order or a prison licence and post sentence supervision. A number of requirements/conditions can be attached to these orders that could require the offender to undertake certain rehabilitative or punitive activities or restrict their behaviour, e.g. where they live or who they can have contact with. These vary according to the type of order.

The NPS delivers two accredited group work treatment programmes for adult males who have committed sexual offences and who are assessed as posing a medium or higher risk of re-offending using the Risk Matrix 2000 risk assessment tool. Attendance on the programme will likely be a specific requirement/condition of their sentence or licence.

Horizon is an accredited group work programme for men aged 18 and over who have a conviction for a sexual or sexually motivated offence/offences and iHorizon is specifically for men aged 18 and over who have been convicted of an internet sexual offence.

Both programmes are built upon a bio-psycho-social model of change. In this model, recognition is given to biological causes of offending, particularly the impact of brain trauma and childhood adversity, of psychological factors, particularly sexual interests, problem solving and self-regulation, and of social factors, in terms of the impact of other people in the development of vulnerabilities to offend, and in promoting desistance.

Horizon and iHorizon provide an [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) informed response for men with sexual convictions who are serving prison or community sentences. They have a strengths based approach which means they aim to increase psychological, social and emotional strengths to assist participants to desist from crime. They are also future focused, in that participants are encouraged to set goals to enable them to engage in constructive, positive, offence free future lives, supported by the skills they learn in the programme.

By completing work within each of the above Blocks, Horizon and iHorizon aim to help participants to:-

* Stop and think to manage their life, particularly with regard to impulsivity and low self-control (Horizon)
* Cope better with life’s problems (Horizon)
* Manage strong unhelpful feelings (Horizon)
* Manage their internet use (iHorizon)
* Have a long term close relationship, encouraging pro-social support and relationships
* Have close family and friends who do not commit crime, contribute meaningfully to their family and community.
* Manage unhealthy sexual thoughts and behaviours whilst strengthening healthy thoughts and behaviours relating to sex
* Have a positive self-identity and hope for the future

Men with a programme requirement would also be allocated an offender manager for on-going risk assessment and management of any other issues related to their offending. There is no group-work treatment provision for female sexual offenders, who are worked with one-to-one by their offender manager using Maps for Change (v2) a strengths based compendium of exercises.

Other provision that can be used with very specific groups of sexual offenders as part of a risk management plan include the use of Polygraph examinations and medication.

**Health:**– People can be sectioned under the mental health act or be subject to hospital orders or have a mental health requirement as part of a criminal Court order

[**Social Care**](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)**:** – Care Orders / Supervision Orders – can have requirements of ‘contact’ with the child / young person

Civil and Criminal Courts can impose: – Anti Social Behaviour Orders – with who not to contact and where not to go.

**Missed Cases**

Since the requirement to consider disqualification orders came into force on 11 January 2001, there have been a number of cases in which orders should have been considered but were overlooked. The Criminal Justice Act 2003 introduced a discretionary power for the CPS to make retrospective application to the court for an order in those cases.

**Faith and Culture Safeguarding Children Checklist**

For use by all practitioners involved in safeguarding children.

Black & Minority Ethnic (BME) families often live with circumstances that reduce or completely obstruct their ability, with or without a professional safeguarding support plan, to do the things they need to do to keep their children safe. **Ask yourself the following questions:**

**If this parent…**

1. Cannot speak, read or write English, will s/he be able to e.g. get a job, arrange suitable childcare, register with a GP, pursue a legitimate asylum claim, understand the law etc?
2. Fears that the ‘State’ is authoritarian, will s/he be able to register with a GP, engage with the local children’s centre, talk to the school about their child’s progress/difficulties, call social services or the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) if necessary e.g. for help with domestic violence?
3. Lacks strong social networks, will s/he be able to cope with the stresses of child rearing and the tensions and emergencies of everyday living?
4. Lives in temporary housing, e.g. B&B, will s/he be unsettled, moving at irregular intervals to new and unfamiliar areas, not able to begin building a supportive social network, needing constantly to engage with a new GP, children’s centre, school etc?
5. Is living below the poverty line, will s/he have the added burden of not being able to buy enough food and clothing, keep warm enough, travel as needed or give things to their child as they would like, to add to the stresses of child rearing and the tensions and emergencies of everyday living?
6. Has a child who is of a different appearance and culture to them, e.g. a single mother whose child has inherited their father’s appearance (and as a young person chooses their father’s culture), will the mother’s skills and the child’s identity and self-esteem be sufficiently resilient?
7. Is living in a close-knit community, will s/he be too scared or ashamed to engage with statutory and other services for herself e.g. domestic violence, sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)/rape, repudiating female genital mutilation or spirit possession, or for her child e.g. honour based violence or sexual promiscuity?
8. Has a perspective on parenting practices underpinned by culture or faith which are not in line with UK law and cultural norms, will s/he put their child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through e.g. leaving young children at home alone, exercising robust physical punishment, forcing a child into marriage etc?
9. Recognises his/her faith or community leader as all powerful, will s/he put their child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) rather than questioning the leader?
10. Puts a very high value on preserving family honour, will s/he put their child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) rather than ‘exposing the family to shame’ in their community?

**and, if this young person…**

1. Is compromised in relation to his/her community, through being ‘westernised’ e.g. sexually active (incl. teenage motherhood), having a girl/boyfriend not from the same community; or by having a stigmatising experience e.g. sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), mental ill health or a disability, will s/he be able to seek help to keep safe from the community or statutory and other services?
2. Has strong allegiance to a group or gang, e.g. radicalised, will this stop him/her from seeking help from the community or statutory and other services, to stay safe?

**2. Introduction**

**2.1 Purpose of this Guidance and Intended Audience**

This practice guidance has been developed to assist clear insight and effective action to protect and promote the welfare of children living in circumstances which appear to be complex because of their faith, culture, nationality and possible recent history.

This guidance is for use by all professionals (the term includes managers, staff and volunteers) who have contact with children living in families from minority ethnic groups and communities, and who therefore have responsibilities for safeguarding and promoting their welfare.

[**The London Safeguarding Board**](http://www.londonscb.gov.uk/) developed this approach in 2010 after a series of projects were completed across various London Boroughs. This practice guidance draws upon this work, but has been adapted to be relevant to staff working in all agencies across Cambridgeshire and Peterborough. Particular acknowledgement to colleagues in Southend for sharing their policy within the regional network.

Dealing with the variety of need that children and young people in Cambridgeshire and Peterborough have is best achieved by professionals understanding the underlying principles of good practice, developing the expertise and confidence to apply them and doing so with knowledge, information and understanding of a child’s specific circumstances – e.g. their and their family’s culture and faith and relationship with the local community and wider UK society. This practice guidance seeks to support this.

**2.2 Professional Responses**

Working Together 2015 which identifies physical, sexual, emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect provides the statutory framework for protecting children and promoting their [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) regardless of their faith, culture and circumstances.

This guidance sets out practice principles and an approach to support effective safeguarding of children across different ethnic group, religions and cultural background and communities. The framework comprises six competencies for professionals, which seek to assist the professional to be clear about the risks from neglect and/or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) to a child’s health and development. At the same time, the framework should assist the professional to correctly identify the positive and negative factors in the child and family’s lived experience which increase or decrease that risk, which are related or attributed to the culture and/or faith of the child, the family and the group or community within which the family lives.

The framework should be applied by the professional as a process integrated with and complementary to the Cambridgeshire and Peterborough LSCB Child Protection Procedures, and any other locally approved procedures i.e. the Early Help Assessment or specialist assessments (e.g. for speech and language therapy (SALT), child and adolescent mental health services [**CAMHS**](http://trixresources.proceduresonline.com/nat_key/keywords/camhs.html), disability or chronic ill health, youth offending etc) and the case management, care planning and reviews which follow from these assessments. Practitioners should be supported in identifying the level of need and the appropriate service to refer to by the use of the [**Effective Support for Children and Families (Threshold) Document**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/threshold-document/)

The six competencies in this [cultural competence](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/) framework should be applied to any case where there are concerns that a child is in need of additional support or of protection from [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and the child and/or his/her family are from a minority ethnic culture, faith group or community.

The six competencies should be re-applied continuously throughout the management of the case to assist professionals to maintain clarity about the different aspects of the child’s health and development and the factors in the other domains of an Assessment.

Assessments of parenting will be influenced by the child / family’s culture and / or faith. These influences can obscure or exacerbate the symptoms which would alert professionals to the risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child.

Professionals should use the information that they are signposted to in other key documents of this guidance as prompts to further inquiry. They describe the type of issue which would underpin steps 1 – 3 in the Framework and which should prompt the actions in steps 5 and 6. These 6 key areas are outlined in figure 1 below and expanded on in section 2.

**Figure 1**

|  |
| --- |
| This practice guidance sets out a framework of six competencies for effective safeguarding children practice. These are based on professionals being competent in:  1.     Knowing how a healthy child or young person presents and behaves – so that the professional can recognise signs of distress and impaired development and intervene as early as possible to protect and promote [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/); acted on quickly and appropriately;  2.     Listening to children and taking what they say seriously – so that their distress can be understood;  3.     Knowing how to undertake a really good holistic assessment. Depending on the circumstances the assessment can be brief or in-depth, but it must address all three Assessment Framework domains in order not to miss a key factor;  4.     [Cultural competence](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/) – so that the professional is self-aware enough not to alienate the child or family and avoids being blinded or prejudiced by faith or cultural practices (and loses sight of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or potential [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child);  5.     Knowing, learning about or seeking expert advice on the particular culture and/or faith by which the child and family lives their daily life;  6.     Knowing about and using services available locally to provide relevant cultural and faith-related input to prevention, support and rehabilitation services for the child (and their family). |

**2.3 National and Local Guidance**

In recent years, a number of national and local practice guides and resource packs have been produced to assist professionals intervene to protect and support children as appropriately as possible. These provide detail on specific issues and should be read in conjunction with this guidance wherever possible. All of these can be accessed on the Cambridgeshire and Peterborough LSCB website, along with the local multi-agency procedures for safeguarding children. It is important to note that this site is regularly updated to reflect the latest national guidance and advice. The website also has information about LSCB training.

**2.4 Terminology Used:**

‘**Child**’ is defined as children up to their 18th birthday, and a ‘professional’ as any individual working in a voluntary, employed, professional or unqualified capacity, including foster carers and approved adopters. ‘Parents’ refers to parents and carers.

‘**Ethnicity**’ refers to a group of people whose members identify with each other through a common heritage, such as a common language, culture (often including a shared religion) and ideology that stresses common ancestry and/or endogamy (the practice of marrying within a specific ethnic group, class, or social group) Everyone belongs to an ethnic group, whether it is the ethnic majority or ethnic minority.

A ‘**minority**’ is a sociological group which does not make up a dominant majority in terms of social status, education, employment, wealth and political power. An ethnic minority group or community may be recently immigrant or have been settled in the UK for quite a few years. Furthermore, within a group or community different families will have different histories of settlement in the UK. Families will also differ; some born outside the UK whilst others were born here. Minority status may reflect their faith-related or travelling culture. The group or community may have a long history of having lived in the UK

The term ‘**safeguarding and promoting the welfare of children**’ is defined 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;
* Enabling children to have optimum life chances and enter adulthood successfully.

See [**Section 4, Faith & Culture and the Potential Vulnerability of Children**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/safeguarding_cultural_and_faith_communities/#4_Faith_Culture_and_the_Potential_Vulnerability_of_Children) for detailed definitions of ‘culture’ and ‘faith’.

**3. Six Competencies for Effective Safeguarding Children Action**

**3.1 Competency 1: Child Development**

When family circumstances appear complex, clarity of purpose comes from keeping the child and his or her needs in focus. To do this, professionals must:

* Be able to distinguish a healthy child from one who’s health and development is being impaired due to [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect;
* Consider the child’s behaviour and development as a possible indicator of the child’s experience within the family;
* Be able to see past the child’s culture to identify actual or potential impairment to his or her health and development.

Professionals and their agencies should strive constantly to raise their level of knowledge and understanding of child development, the essential components of good parenting and the presentation of a child who needs help. This is the single most effective means of identifying and protecting a child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect. It provides the benchmark for recognising when a child is not thriving and developing as he or she should – compared to what could be reasonably expected of a similar child.

**3.2 Competency 2: Listening to Children**

**Why do children not disclose**[**abuse**](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)**?**

* Fear of not being believed;
* Fear of repercussions;
* Not being asked the question;
* Not knowing, when young, that the abusive behaviour is not normal.

A child has the right to have his or her views taken into account (Article 12). The single most consistent shortfall in safeguarding work with children in the UK has been the failure of all professionals to see and speak to the children, observe how they are, listen to them and take serious account of their views, and see the situation from their perspective and experience.

**3.3 Competency 3: Sound Holistic Assessments**

‘Knowledge and understanding of culture and faith is critical to effective assessments of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through neglect and/or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). However, culture and faith should not be used as an excuse to [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and must never take precedence over children’s rights’ *Safeguarding Children’s Rights Special Initiative: Final Evaluation Report* (Tavistock and Portman NHS Foundation Trust / University of East London Centre for Social Work Research, 2011).

A key message from the Munro Review was that everyone working with children, parents and families must undertake good, proportionate assessments and make full use of their professional expertise and that of others in the professional multi-agency network. Additionally, it is important to recognise children and young people as experts in their own lives.

**Proportionate assessments** are important. When there are concerns that a child may be at risk of or already experiencing neglect and/or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), an assessment needs to be undertaken. For some children, a brief assessment is all that is required prior to offering services and for others the assessment needs to be more in-depth, broader in scope, and take longer in order to get a sufficiently accurate understanding of the child’s needs and circumstances to inform effective planning. Regardless of how in-depth the assessment is, professionals should consider three areas in a child’s life:

* The child’s growth and development;
* The parent/s ability to meet the child’s needs – including their capacity to keep the child safe from significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through neglect and/or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/); and
* The amount of support the child can get from his or her wider networks.

**Professional expertise** – the Munro Review sought to address the issue that professional practice should not be focused on compliance with guidance.

*‘…procedures can lull people into a passive mindset of just following the steps, and not really thinking about what they are doing.’*

The Review argues that dealing with the variety of need which children and families present is better achieved by professionals understanding the underlying principles of good practice and developing the expertise to apply them, taking account of the specifics (in this context, the family’s faith and culture) of a child’s or young person’s circumstances.

**Religion or spirituality** is an issue for all families whether white or black. A family who do not practice a religion, or who are agnostic or atheists, may still have a particular view about the spiritual upbringing and welfare of their children. For families where religion plays an important role in their lives, it will also be a vital part of their cultural traditions and beliefs. Some families may also have *specific mores or belief systems* that are not instantly obvious but may also impact upon their children’s development.

**Culturally competent assessment**

It is crucial for professionals to work from culturally competent perspectives, particularly when an assessment is required. Professionals should have a basic level of cultural understanding and awareness when working with children and families from minority ethnic culture and faith groups and communities. The absence may lead to an inaccurate outcome for individuals within the family as well as overlooking safeguarding issues. Assessments should always be undertaken using a variety of sources of information to support professional decision-making, including the family, other professional perspectives and historical information. The latter can often prove difficult to source due to the fact that families have moved from other countries.

**Focusing on family strengths and resilience**

In the areas of family strengths, community strengths, and cultural strengths, the way people live their lives are much more similar than different. These similarities are solid common ground on which to build partnerships to nurture and protect our children.

Strong families share eight qualities:

1. Good communication and conflict resolution;
2. A sense of belonging, with shared values, beliefs and morals;
3. Shared activities;
4. Respect for family members’ individuality;
5. Affection;
6. Support and reassurance;
7. Commitment/ prioritising the family’s [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/);
8. Resilience

Silberberg S. Searching for Family Resilience (2001).

**3.4 Competency 4: Cultural Competence**

Successful engagement depends largely on a respectful and culturally sensitive approach, rather than on the ethnicity and cultural/ religious background of the outreach workers.

[Cultural competence](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/) is respectful of and responsive to the beliefs, practices and cultural and linguistic needs of diverse communities. There are five essential elements that contribute to an individual professional’s, and a whole service’s, ability to become more culturally competent. The professional or service must:

* **Value diversity** – valuing diversity means accepting and respecting differences. Even how one chooses to define family is determined by culture. Diversity between cultures must be recognised, but also the diversity within them. People generally assume a common culture is shared between members of racial, linguistic, and religious groups, but individuals may share nothing beyond similar physical appearance, language, or spiritual beliefs;
* **Cultural self-assessment** – through the cultural self–assessment process, staff are better able to see how their actions affect people from other cultures. The most important actions to be conscious of are usually taken for granted;
* **Consciousness of the dynamics of cultural interactions** – there are many factors that can affect cross–cultural interactions. There often exists an understandable mistrust towards members of the majority culture by historically oppressed groups;
* **Institutionalisation of cultural knowledge** – the knowledge developed regarding culture and cultural dynamics must be integrated into every facet of a service or agency. Fully integrated cultural knowledge is the only way to achieve sustained changes in service delivery;
* **Adapt to diversity** – the fifth element of [cultural competence](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/) specifically focuses on changing activities to fit cultural norms. Cultural practices can be adapted to develop new tools for treatment – i.e. a child or family’s cultural background provides traditional values that can be used to create new interventions.

**3.5 Competency 5: Informed Practice**

All professionals working with children, parents or families whose faith, culture, nationality and possibly recent history differs significantly from that of the majority culture, must take personal responsibility for informing their work with sufficient knowledge of the relevant faith and/or culture to be able to effectively protect the child/ren and promote their welfare.

They must be ‘professionally curious’ about situations or information that arising in the course of their work. They should investigate these both by allow the family to give their account as well as researching such things by discussion with other professionals or by researching the [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) base. Examples of this might be around attitudes towards and acceptance of services e.g. health; dietary choices; choice of education provision or school attendance.

Professionals may choose to educate themselves about particular faiths or cultures, perhaps if they anticipate working with significantly more children and families from that background. Alternatively, or in addition to their own learning, a professional may seek expert advice about a particular culture and/or faith on an ongoing basis throughout their work with the child and family – from a local, regional, or national source.

**3.6 Competency 6: Partnership with Specialist Services and Parent, Communities and Faith Groups**

Professionals working with children, adults with caring responsibilities and families whose faith, culture, nationality and possibly recent history differs significantly from that of the majority culture, must take personal responsibility for utilising specialist services’ knowledge to inform their practice in individual cases. This includes:

* Knowing which agencies are available to access;
* Having contact details to hand;
* Timing requests for expert support and information appropriately to ensure that assessments, care planning and review are sound and holistic. For BAME communities, accessing appropriate services is a consistent barrier to them fully participating in society, increasing their exclusion and potential for victimisation.

Since the Children Act 2004, there is a responsibility on parents, communities, faith and community groups, and professionals to proactively safeguard and promote the welfare of children so that the need for action to protect them from [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) is reduced.

Effective safeguarding children activity means not only partnership between the majority population and minority ethnic culture and faith groups and communities, but also between the different minority groups and communities.

**4. Faith & Culture and the Potential Vulnerability of Children**

Culture can be understood as the social heritage of a group, organised community or society. It is a pattern of responses discovered, developed, or invented during the group’s history of handling problems which arise from interactions among its members, and between them and their environment. These responses are considered the correct way to perceive, feel, think, and act, and are passed on to the new members through immersion and teaching. Culture determines what is acceptable or unacceptable, important or unimportant, right or wrong, workable or unworkable. It encompasses all learned and shared, explicit or tacit, assumptions, beliefs, knowledge, norms, and values, as well as attitudes, behaviour, dress, and language.

Culture changes, reflecting a group’s responses to new experiences between each other and between them and their environment. However, this usually takes time because changes become embedded only through being passed on to new generations.

Faith is a belief system which forms attitudes and behaviours but crucially informs one’s identity over a period of time. It can be understood as ‘spirituality’ – defined as searching for purpose, meaning and morality, which can often, but not always, be expressed as a ‘religion’ – which may include regular public worship such as church attendance.

Faith very often underpins culture. However, people from different cultures can have a strong allegiance through the same faith. If a parent is behaving / expressing attitudes towards children which raise serious concerns based on beliefs, to what extent is this behaviour supported by the faith group? If the individual behaviour is not being reinforced by the wider group then might joint working with the faith group to help the parent prove a productive way forward? On the other hand if such practices / attitudes are being fed by the faith group who are essentially therefore part of the problem (with the potential for other parents being likewise influenced) can this be addressed more widely by engaging on the issues with faith leaders?

For children and their families whose faith, culture, nationality and possibly recent history, differs significantly from that of majority culture families, there are a range of issues which can potentially obstruct their ability to seek help, protect themselves or fulfil their role as protective adults. The majority of these issues have their basis in the culture and/or faith of the family and their community. However, there also issues relating to the families’ recent history and current living circumstances.

Children and their parents may be newly immigrant and unable to speak, read or write English, at all or well. Some parents may have been in the UK for some time, but have not had the opportunity to learn English, for a range of reasons. The consequences of this are that the parent may not be able to, for example, get a job, arrange suitable childcare, register with a GP, understand the law etc. The child may not be able to seek help if he or she is being neglected, harmed or fearful of being harmed, be it at home, school, a sports or faith group etc.

Families can struggle when different generations within a family have different levels of proficiency in the different languages spoken. The parents’ lack of fluency in the new language and the children’s lack of fluency in the ‘mother-tongue’ may subvert authority in the family.

The power of children is increased because they become ‘cultural brokers’, while the power of parents is decreased because they depend on their children’s assistance to survive in the new world. The inordinate amount of power children may acquire because of their language proficiency can be at the source of conflicts over authority issues. It also magnifies children’s conscious or unconscious fears that their parents are now unable to protect them.

All agencies need to ensure that they are able to communicate fully with parents and children when they have concerns about child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect, and ensure that family members and professionals fully understand the exchanges that take place. Agencies should make arrangements to ensure that children are seen with an interpreter within the same timescales for assessment or investigation as for any other intervention.

Newly arrived families may be reluctant or averse to engaging with statutory services. This may be because they are not confident in navigating the UK public services system, or it may be as a result of their experience of state authoritarianism in their home country. Some Gypsy and Traveller families may respond in the same way, owing to negative life experiences. The consequences of this are that both adults and children may be unforthcoming when approached by statutory services, or actively avoid any engagement, e.g. registering with a GP, engaging with the local children’s centre, talking to the school about their child’s progress/difficulties, calling social services or the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) if necessary.

Children and their parents who are newly arrived are likely to have weak or non-existent social networks. Families may also lack extended family in the UK. This means that there is limited, if any, support for the stresses, tensions and emergencies of child rearing and family life for parents and children. There may be no ‘significant others’ for a child to confide in, or to advocate for or advise a parent.

Children and families who are either newly arrived or have been in the UK for some time, but still living below the poverty line, may be in temporary and/or overcrowded/ multi-occupancy housing. Families in this situation are unlikely to feel safe. Parents may leave their children at home with other tenants, either because of work demands, or because this practice was common in their home communities. Families may be unsettled if they are moved at irregular intervals to new and unfamiliar areas. This means that they are not able to begin building supportive social networks to mitigate stress and isolation in any local area, and will need constantly to engage with a new GP, children’s centre, school etc. The children will not have established routines and activities to stimulate their development and confidence.

In addition to housing issues, the family may be struggling to buy enough food and clothing, keep warm enough, travel as needed or give things to their child as they would like.

For insecurely accommodated Gypsy and Traveller families, or where literacy issues exist, the impact of frequent movement and/or limited information about local services is likely to have a negative impact on the ability to seek help by children, mothers or any other family members who need support, who are being harmed or who are aware that it is occurring. This exacerbates a situation similar to that of other ethnic minority groups and communities, in which families struggle with the stress of low incomes, feeling excluded, being subject to racism, having a distrust of statutory services and the services being ignorant of their culture and cultural strengths.

“Many Gypsies and Travellers are caught between an insufficient supply of suitable accommodation on the one hand, and the insecurity of unauthorised encampments and developments on the other: they then face a cycle of evictions, typically linked to violent and threatening behaviour from private bailiff companies. Roadside stopping places, with no facilities and continued instability and trauma, become part of the way of life. Health deteriorates, while severe disruptions occur to access to education for children, healthcare services and employment opportunities.”

Children and families from minority ethnic communities may be experiencing racism and harassment. If they are newly arrived in this country this may be their first experience of racism and harassment. It is likely to exacerbate feelings of distrust, particularly if some of the racism is perpetrated by individuals in public services.

The parent and child may have a different appearance and culture to each other, e.g. a single mother whose child has inherited their father’s appearance (and as a young person chooses their father’s culture). In some cases the mother’s skills and the child’s identity and self-esteem may not be sufficiently resilient.

Cultural identity based on ethnicity is not necessarily exclusive. People may identify themselves as British in some circumstances and as part of a particular culture (e.g. Gypsy/Roma, Pakistani or Bangladeshi) in other circumstances. They may also identify with more than one culture.

Cultural identity is an important contributor to people’s [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/). Identifying with a particular culture helps people feel they belong and gives them a sense of security.

Having two cultural identities is common among the second and third generations and people may switch between identities in different contexts. The older generation often worry about the younger generation losing their cultural and ethnic identity, and parents may strive to instil traditional values from their country of origin in their British born children. [www.coi.gov.uk/aboutcoi.php?page=326](http://www.coi.gov.uk/aboutcoi.php?page=326)

The parent/s may have a perspective on child rearing practices underpinned by culture or faith which are not in line with UK law and cultural norms, and they may put their child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through actions such as leaving young children at home alone, exercising harsh physical punishment, forcing a child into marriage etc.

A mother may have low status in her family and community because she is a woman and may not have the power or confidence to easily protect herself and her child from [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

Sensitivity toward other cultures does not imply unquestioning acceptance of patriarchal definitions of cultural identities and behaviours. The challenge for professionals is how to preserve sensitivity and respect for others and their cultural differences while working to achieve family functioning which accommodates women’s and children’s rights.

The parent/s may recognise their faith or community leader as all powerful, and may put their child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) rather than questioning the leaders, as do to so could cause further isolation, rejection and even in some cases, total banishment from the community that they are dependent upon.

The parent/s may put a very high value on preserving family honour, and may put their child at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) rather than ‘exposing the family to shame’ in their community. In addition, young people may be compromised in relation to their community, through being ‘westernised’ e.g. sexually active (incl. teenage motherhood), having a girl/boyfriend not from the same community; or by having a stigmatising experience e.g. sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), mental ill health or a disability. She/he may not feel or be able to seek help to keep safe from the community or statutory and other services.

**5. Child Poverty**

In the UK, poverty rates vary enormously according to the ethnicity of the household. Within black or black British households, 48% of children are living in poverty. This rises to 67% in Pakistani and Bangladeshi households, 51% of black and black British children and 48% of children in Chinese or other ethnic groups live in poverty – compared with 27% of White children. This presents the government with a serious challenge – without targeted policies, ethnicity will continue to determine children’s life chances.

Worklessness is a key driver for poverty, 72% of White women are economically active compared with just 27% of Bangladeshi and 30% of Pakistani women.

Work it is not a guaranteed route out of poverty – 54% of Pakistani and Bangladeshi children in working households are in poverty compared to just 12% of White Children. Other contributing factors to household poverty are where there are Lone parent households, large families and families with a disabled child.

Asylum seeking families – asylum seeking families and their children are among the most disadvantaged groups in the country. Asylum seeking families are not allowed to apply for permission to work for the first 12 months of their application. This means that they are reliant on state benefits, makes it more difficult for them to integrate into their community and reduces the chances of them finding employment if they are given refugee status.

Children living in poor housing face a number of consequential difficulties– there is a shortage of affordable housing due to high rents in the private sector and a lack of investment in maintaining a good standard of social housing. Children who live in bad housing are more likely to suffer from poor health, and to suffer from disability or long-term illness. They are also less likely to settle into the area they live in and more likely to run away from home. Children living in poor housing are more likely to have poor educational attainment, to have been excluded from school and to leave school with no GCSEs. In Peterborough, there are children and young people living in houses with multiple occupants including other families and individual adults. The risk arising from this for children and young people should always be considered by professionals working with children and young people.

**5.1 The Impact of Poverty**

Poverty:

* Increases the incidence of racial, ethnic and religious hatred;
* Increases [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) against women and children;
* Is directly linked to violence;
* Dampens the human spirit creating despair & hopelessness;
* Underlies multiple problems facing children and families;
* Directly affects infant mortality, impairs mental development, exacerbates learning disabilities and drug & alcohol [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* Results in suicide, depression, and severe mental illness;
* Is a major factor in homelessness.

**5.2 The Relationship between Poverty and Abuse and Neglect**

There is an association between poverty and an increased risk of neglect and physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). The most widely accepted explanation for the link focuses on stress. The multitude of factors associated with poverty and social deprivation (especially if they are compounded by drug misuse or mental health problems), increase vulnerability to stress and make good parenting difficult. (*Sharma. N., It doesn’t happen here – The reality of child poverty in the UK*).

There is a strong correlation between poverty and neglect. One study found that 98% of the families whose children were at risk of emotional maltreatment or neglect were characterised by the extreme poverty of their material environment – reflected in the fact that 59% lived in over-crowded housing conditions, with 56% of parents reporting high levels of emotional stress.

**6. Other Specific Issues and Vulnerabilities**

There are many different issues that practitioners need to be aware of both in terms of the additional vulnerabilities that children and young people face arising from diversity or where their background means they are more likely to experience the situations:

* Poverty;
* Highly mobile families/ Insecurely accommodation;
* Being newly arrived in this country;
* Language barrier;
* Family structure and position in the family;
* Private fostering;
* Spirit possession and witchcraft – especially where there is a poor bond between child and parent or where there is a child with a difference;
* Child with a disability;
* Traumatic recent history;
* Being a looked after child.

And specific safeguarding concerns related to diversity and culture:

* Forced Marriage;
* Female Genital Mutilation;
* Honour Based violence;
* Trafficked children.

Rather than repeating what is already so well examined, the reader should refer to the [**LSCB website**](http://www.safeguardingcambspeterborough.org.uk/) for the local and national guidance and to the London Safeguarding Children Board guidance on [**Safeguarding Children in minority ethnic culture and faith (often socially excluded) communities groups and families (Dec 2011)**](http://www.londonscb.gov.uk/culture_and_faith).

**7. Bibliography**

[**Cultural Competence**](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/)**in Safeguarding**

The [**London Safeguarding Children Board website**](http://www.londonscb.gov.uk/culture_and_faith) hosts examples of good practice in safeguarding. <http://www.londonscb.gov.uk/culture_and_faith/>

**Serious Case Reviews**

The [**NSPCC website**](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/serious_case_reviews_homepage_wda82779.html) contains all of the overview research reports in to Serious Case Reviews.

Brandon et al (2011) developed a further paper arising from their study of the review of Serious Case Reviews of 2009-11: ‘Child and family practitioners’ understanding of child development’

The Victoria Climbie Inquiry: Report of an Inquiry by Lord Laming (Lord Laming, 2003)

**Key Reports into Child Protection and Early Help**

[**Munro Review of Child Protection: A child-centred system**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf) (Professor Eileen Munro, 2011).

[**Early Intervention: The Next Steps (Graham Allen MP, 2011)**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf).

[**The report of the Independent Review on Poverty and Life Chances**](http://webarchive.nationalarchives.gov.uk/20110120090128/http:/povertyreview.independent.gov.uk) (Frank Field MP, 2010).

**Other Organisations**

[**Protecting CHILDREN and uniting FAMILIES ACROSS BORDERS**](http://www.cfab.org.uk/).

**Misuse of substances**

**1. Definition**

Substance misuse refers to the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of drugs and/or alcohol. Whilst there may be different treatment methodologies for adults with these problems, they are considered together because the consequences for the child are quite similar. Substance misuse refers to both  illicit drugs, alcohol, prescription drugs and solvents, the consumption of which is either dependent use, or use associated with having harmful effect on the individual or the community.

Many substance misusing adults also suffer from mental health problems, which is described as Dual Diagnosis and there may be several agencies, from both Adult and Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), who are working with the family.

National Serious Case Reviews and Domestic Homicide Reviews have identified [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/), parental mental ill health and drug and alcohol misuse as significant factors in families where children have died or been seriously harmed.

**2. Risks**

Substance misuse can consume a great deal of time, money and emotional energy, which will unavoidably impact on the capacity to parent a child. This behaviour also puts the child at an increased risk of neglect and emotional, physical or sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), either by the parent or because the child becomes more vulnerable to [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) by others.’

Children’s physical, emotional, social, intellectual and developmental needs can be adversely affected by their parent’s misuse of substances. These effects may be through acts of omission or commission, which have an impact on the child’s welfare and protection.

Children may be introduced to drug and alcohol misuse at an early age by the behaviour of the parents and the availability of the substances within the home.

All agencies need to work together in tackling the problems caused by substance misuse in families in order to safeguard children and promote their well being. Parental misuse of drugs and/or alcohol may not impact on parenting capacity and parents will not [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect their children. It is important not to generalise or make assumptions about the impact on a child of parental/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) drug and/or alcohol use. It is, however, important that the implications for the child are properly assessed having full regard to the parents/carers ability to maintain consistent and adequate care. Equal regard should be given to each and every child’s level of dependence, vulnerability and any special needs.

Where there is concern that a parent is involved in substance misuse, the impact on the child needs to be considered, including:

* The child’s physical safety when the parent is under the influence of drugs and/or alcohol;
* Children can suffer chronic neglect, from before birth and throughout childhood;
* Possible trauma to the child resulting from changes in the parent’s mood or behaviour, including exposure to violence and lower tolerance levels in the parent;
* The impact of the parent’s behaviour on the child’s development including the emotional and psychological well-being, education and friendships;
* The impact on newborn babies who may experience foetal alcohol syndrome or other drug withdrawal symptoms;
* The extent to which the parent’s substance misuse disrupts the child’s normal daily routines and prejudices the child’s physical and emotional development;
* The impact on the child of being in a household where illegal activity is taking place particularly if the home is used for drug dealing and the children may come in to contact with risky adults;
* How safely the parent’s alcohol and/or drugs and equipment are stored as children can be at risk of ingesting substances or injuring themselves on drug paraphernalia;
* Children are particularly vulnerable when parents are withdrawing from drugs;
* Dangerously inadequate supervision and other inappropriate parenting practices;
* Intermittent and permanent separation;
* Inadequate accommodation and frequent changes in residence;
* Children being forced to take on a caring role and feeling they have the responsibility to solve their parent’s, alcohol and drug problems.

The circumstances surrounding dependent, heavy or chaotic substance misuse may inhibit responsible childcare, for example, drug and / or alcohol use may lead to poor physical health or to mental health problems, financial problems and a breakdown in family support networks.

**3. Indicators**

There are many reasons why adults take drugs or drink alcohol. If doing so has an impact on the individual, their family or wider society then it may be regarded as misuse. Parents may be aware that their behaviour has an impact on their child but there is a risk in focusing on the adult’s behaviour. The real impact on the child can be overlooked or seen as a secondary consideration.

To be healthy and to develop normally, children must have their basic needs met. If a parent is concerned with funding an addiction, or is under the influence of drugs or alcohol, they are unlikely to be able to achieve this consistently. A disorganised lifestyle is a frequent consequence of substance misuse. Parents may fail to shop, cook, wash, clean, pay bills, attend appointments etc.

Substance misuse may affect a parent’s ability to engage with their child. It may also affect a parent’s ability to control their emotions. Severe mood swings and angry outbursts may confuse and frighten a child, hindering healthy development and control of their own emotions. Such parents may even become dependent on their own child for support. This can put stress on a child and mean they miss out on the experiences of a normal childhood.

Other consequences of substance misuse – lost jobs, unsafe homes (littered with half empty bottles or discarded syringes), relationship breakdowns, severed family ties and friendships, and disruption of efforts made by services to help – are also likely to affect a child.

Any professionals, carers, volunteers, families and friends who are in contact with a child in a drug / alcohol-misusing environment must ask themselves “What is it like for a child in this environment?”

**4. Protection and Action to be Taken**

Where there are concerns by practitioners involved with a family about a child living in the environment of substance misuse an assessment of the parent’s capacity to meet the child’s needs should take place. This should establish the impact on the child of the parent’s lifestyle and capacity to place the child’s needs before those of their own. Where there are safeguarding concerns a referral to Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) in line with the [**Referrals Procedures**](http://cambridgeshirescb.proceduresonline.com/chapters/contents.html#refer) should be made and the practitioners from adult services, or other relevant agencies, should work in collaboration with Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

Where any agency encounters a substance user who is pregnant and whose degree of substance misuse indicates that their parenting capacity is likely to be seriously impaired, they must make a referral to Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

The majority of pregnant substance misusing women will have been identified by maternity services and referred to the Substance Misuse Team. The [**Care Planning Approach / Care Co-ordination Approach**](http://www.nhs.uk/CarersDirect/guide/mental-health/Pages/care-programme-approach.aspx) will apply including input from the link midwives and a social worker from Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), who will be invited to any meetings taking place in respect of the child/ren.

Where a newly born child is found to need treatment to withdraw from substances at birth, an assessment and a pre-discharge discussion should take place and consideration should be given to making a referral to Children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) in line with the [**Referrals Procedures**](http://cambridgeshirescb.proceduresonline.com/chapters/contents.html#refer) before the child is discharged home.

Specialist Substance misuse services should be invited to and should attend and provide information to any meeting concerning the implications of the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s substance misuse problems for the child, including Child Protection Conferences and Child in Need meetings.

There is a clear need to assess the impact of the substance misuse on the child as well as the wider family and community context. Some adult services may be reluctant to share information because of concern about confidentiality. However, the needs to safeguard children should be paramount and agencies with information regarding the parent will have a valuable contribution to make. In these circumstances, practitioners should seek advice from the Safeguarding leads in their organisation, if they are unsure as to what information should be shared, or what action should be taken.

When practitioners make a decision to end their involvement with a parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) with substance misuse problems, or a child who is living with a parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) with substance misuse problems, they should always discuss their plans with the other services who are working with the family, before the case is closed. This is to ensure that any on-going needs can be addressed.

**5. Issues**

Parents’ own needs will need to be addressed and supported. Sometimes parents will be unwilling to access appropriate treatment services or there may be delays in providing services however the child’s needs must not be put on hold without a contingency plan.

Confidentiality is important in developing trust between drug using parents and staff in agencies working with them in relation to their substance misuse, however, practitioners must always act in the [best interests](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/) of the child and not prioritise their therapeutic relationship with the adult.

When a woman with a substance misuse and/or problem attends for antenatal care, she should be encouraged to contact the Substance Misuse Team for assessment and advice on the treatment options available to her.

**6. Further Information**

[**Adfam**](http://www.adfam.org.uk/) – support to families affected by drugs and alcohol.

[**Cambridgeshire Drug and Alcohol Action Team**](http://www.cambsdaat.org/)

[**Inclusion Drug and Alcohol Treatment Service**](http://www.inclusion-cambridgeshire.org.uk/)

[**CASUS (Cambridgeshire Child and Adolescent Substance Use Service)**](http://www.cpft.nhs.uk/casus)

[**National Association for Children of Alcoholics**](http://www.nacoa.org.uk/)

[**Dual Diagnosis – A Good Practice Handbook**](http://cambridgeshirescb.proceduresonline.com/pdfs/dual_diagnosis.pdf)

[**NHS Choices Care Programme Approach**](http://www.nhs.uk/CarersDirect/guide/mental-health/Pages/care-programme-approach.aspx)

[**Hidden Harm – Responding to the Needs of Children of Problem Drug Users**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf)

[**NSPCC Learning from Serious Case Reviews**](http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/briefing-substance-misuse_wda99489.html)

[**Think Child, Think Parent, Think Family**](http://cambridgeshirescb.proceduresonline.com/pdfs/think_child.pdf)

## Policy for the Education of Children with a Parent or Close Relative in Prison or at Risk of a Custodial Sentence

## Context

Children with a parent in prison should be regarded as true victims of their parents’ crimes, often achieving poor outcomes and a high probability of them growing up in poverty and disadvantage. Some of them have complex needs and are from socially excluded families. Research[[1]](#footnote-1) identifies this group as having high level risks of vulnerability and safeguarding with the potential for future offending behaviour, exclusion from school, poor attendance and poor academic achievement.

**Purpose**

**{Name of school}** is committed to support the children and young people who have a parent or close relative in prison. This policy has been endorsed by Cambridgeshire and Peterborough LSCB on ………………..and the school governing body on …………….

The aims of this policy are:

* to raise awareness of the needs of the pupils and students of **{ name of school}** with a parent or close relative in prison
* to secure the educational achievement and attendance of those pupils and student during their time in our school
* to promote their social inclusion and equal opportunities within our school community

**How will we achieve these aims?**

1. All staff and parents will be informed of this policy and the school’s commitment to support children with a parent/close relative in prison. This policy will be available on the school website and to parents on request
2. The document ‘Risks to Children of Prisoners’ information (Appendix 1) will be available on the school website
3. Guidance on ‘Information Sharing and the Seven Golden Rules (Appendix 2) will be available on the school website
4. A member of the school staff will be appointed as ‘Designated Person for Children of Prisoners’ and their role will include:

* Keeping the Head teacher fully informed of pupils or students with a parent in prison
* Liaise with other relevant school staff on a ‘need to know’ basis
* Provide a point of contact in the school for external agencies in order to share information
* Liaise with the family and seek their consent to provide additional support for the child as necessary
* Liaise with other statutory and voluntary agencies as appropriate
* Promote the use of the Early Help Assessment (EHA) to identify the needs of the child unless a Core Assessment has been completed
* Consider calling a multi-agency meeting to address the needs of the child and to indentify a key worker for that child following the completion of a EHA
* Consider the use of an individual education plan for the child concerned
* Monitor the achievement, attendance and behavior of the child with a parent in prison
* Act as an advocate for children with a parent in prison, particularly if the child is a Looked After Child (LAC) as LAC have poor levels of visiting a parent in prison.
* Consider purchase of books and resources on the subject of prisons and prisoners for the school library
* Keep appropriate and current records with reference to information sharing guidance

1. If a parent informs our school that the parent or other close relative of one of our pupils is in prison, we will provide information on the support available to them (Appendix 3)
2. Wherever appropriate our school will include a parent with parental responsibility who is in prison, in the education of their child by making and maintaining contact with that parent. This will be done by forwarding copies of any school report or newsletter, supplying photographs of examples of work and encouraging the pupil to suggest other ways that contact may be maintained

**Guidance for Teachers and staff on practical measures to support**

All staff have a vital role to play in ensuring that a child affected by imprisonment is supported within our school. The secure, stable and consistent routines of school can provide reassurance for a child who is experiencing difficulties in their personal life and an awareness of the emotional health and well-being of our pupils will enable all pupils to feel valued and safe, including those with a parent in prison.

Staff will not necessarily be aware that a child has a relative in prison. In some cases a pupil may confide in a member of staff or drop hints and clues through school work or in conversation.

A member of staff does not need to let the child know that he or she knows that their parent is in prison as the pupil may be unwilling to discuss the issue with anyone in school. It may be that the family of the child merely wish the child’s performance and behavior be monitored for any change.

**Confiding**

If a pupil raises issues concerning the imprisonment of a parent during school time, the following responses may be helpful:

* Allow the pupil to express him or herself
* Listen carefully
* Acknowledge what is said
* Reassure the pupil
* Agree future action with the pupil

**Adhere to the basic principles of responding to any disclosure**

* See the child as an individual with their own specific needs
* Be non-judgmental – the child has not committed a crime
* Don’t ask about the crime
* Acknowledge the child’s preferences
* Follow safeguarding principles if appropriate

**Who to inform – Need to know**

If a child does disclose sensitive information about a parent in prison, it is important to acknowledge their situation and be clear with them about who needs to be told in order to support them. It may be useful to explain the role of the designated/named person in school, and to negotiate and agree with the child what steps need to be taken

.

**Recognising the signs – changes in behaviour and performance**

Children of prisoners may exhibit changes in behaviour and performance that can be likened to a child’s emotional response as in divorce or bereavement. Clearly, the experience of having a parent in prison is about ‘loss.’ The child’s, and the family’s resilience to this loss will determine how it impacts on the child in their behavior and performance at school. There are certain events that can make these changes in a child more apparent and these can include;

* The arrest of parent, carer or sibling
* Finding out about the imprisonment
* A visit to a parent in prison
* A home visit by a parent from prison
* The release of a parent from prison

The following are possible changes in pupils with a parent in prison

* Moodiness
* Chattering
* Bullying
* Difficulty with peers
* Appearing upset
* Appearing withdrawn
* Showing a lack of concentration
* Showing a lack of interest
* Antagonism towards authority
* Tiredness

However, for some children, the removal of a parent to prison may be beneficial to the child and behavior and performance in the classroom may improve.

**Bullying**

Many children of prisoners report being teased or bullied at school. Any form of bullying will be dealt with in accordance with the school’s anti-bullying policy.

**Attendance issues**

Our school takes attendance very seriously and will always promote the importance of attendance. However, we will be considerate of the difficulties that a child with a parent in prison, or at risk of imprisonment may face e.g.

* The child is in court with, or visiting the prisoner some distance from home
* The child is providing support for the remaining parent or siblings, as a young carer
* The child is having difficulty coping with school or is being teased or bullied about having a parent in prison and is becoming disaffected

Attendance will be monitored and if it becomes a concern the school will refer to appropriate agencies for support.

**Particular problems**

Prison visits

Teachers say that performance and behavior of children of prisoners can become more erratic at the time of a prison visit.

If teachers or other staff, have good relationships with pupils who are happy to confide in them, there may be opportunities to allow pupils to take samples of work to show parents when visiting. However, reports or written work, drawings or artwork can be sent by post or email. Although prisoners do not have open access to email, it may be possible for the pupil to send email from school to a prison email address for the information of their parent. Photographic attachments or school work or events may also be sent in this way.

Financial implications

A family may experience significant loss in income with a parent in prison and face severe hardship. Teachers would be aware of the potential difficulties for children of prisoners finding the money for school trips and resources in school. An EHA may have identified these issues and support already put into place.

**Children of prisoners held overseas**

This is a relatively rare occurrence for our community, but can be all the more distressing with a lack of access, distance and unanswered concerns about a prisoner’s welfare.

Organizations and individuals that can provide support in these circumstances include

* Amnesty International
* Local councilors and member of Parliament
* Prisoners Abroad

**Date:**

**Policy review date**:

**Appendix 1**

**What are the risks to children of prisoners achieving their full potential?**

* Children of prisoners have about three times the risk of mental health problems

compared to their peers.

* The sudden removal of a parent from the family creates feelings of separation and loss and may affect the emotional health of the child
* Parental imprisonment can lead children to experience stigma, bullying and teasing
* Children’s caregivers often experience considerable distress during parental imprisonment, and children are often subject to unstable care arrangements
* During the consultation with parents in prison bullying of their children was the greatest concern. Several parents also voiced their concerns that their own children had bullied other children
* Discrimination from members of the local community can have major implications for the children of parents in prison
* Children of parents in prison may be exposed to substance misuse by family members and their peers
* Children of prisoners may experience higher levels of social disadvantage than their peers
* Some families choose not to inform schools that a pupil has a parent in prison. Yet, having a parent in prison can lead to poor attendance, lack of support and isolation for the young person
* Children of prisoners may have to take on more responsibility in the household or take on a caring role
* Children of prisoners may have higher levels of anxiety or worry that prevent them from participating fully in learning
* Children of prisoners have three times the risk of anti-social/delinquent behaviour compared to their peers
* 65% of boys with a convicted parent, go on to offend
* Imprisonment has a negative financial impact on families, leaving families vulnerable to financial instability, poverty and debt and potential housing disruption
* 72% of prisoners were in receipt of benefits before coming into prison
* Costs of visiting the parent in prison may prevent the child from visiting their parent

**Appendix 2**

**Information Sharing**

**Seven golden rules for information sharing**

**1. Remember that the Data Protection Act is not a barrier to sharing information** but providesa framework to ensure that personal informationabout living persons is shared appropriately.

**2. Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

**3. Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.

**4. Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

**5. Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

**6. Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information youshare is necessary for the purpose for which youare sharing it, is shared only with those people whoneed to have it, is accurate and up-to-date, is sharedin a timely fashion, and is shared securely.

**7. Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

**Appendix 3**

Education of a Child with a Parent or Close Relative in Prison – Information for Parents and Carers

The impact on a child

A family has to deal with many changes when a parent or relative goes to prison. Initially there may be a delay in finding out where they have gone or before any visits can be arranged. For a child there may be a sense of confusion and loss and this could affect their behaviour and ability to learn

One difficulty is deciding what to say to the children to explain where the parents is. Some families want to protect the children from distress and create a story such as the parent is working away but this could be difficult to continue if a prison visit is possible. There is also the possibility that the children will find out the truth from someone else

Action for Prisoners’ Families recommends that the key question parents should ask themselves is, ‘When and what shall I tell the children?’ rather than, ‘Shall I tell the children?’ Although difficult, the advice from groups who work with families of prisoners is to be truthful but to be prepared for questions. Action for Children’s Families have produced a useful guide ‘Telling the Children – a guide for the partners and families of prisoners’ that gives practical advice on how to tell children.

Research and experience tells us that children who are worried, upset or anxious can find it very difficult to concentrate and learn in the classroom. They may be embarrassed or angry about having a parent in prison and this may affect they way that they behave in school. Living arrangements and financial circumstances may also change leading to money difficulties in the payment for equipment or school trips and events. This may lead to new emotions and feelings for the child concerned and could have a negative impact on their education and attendance at school.

Who can help?

{Name of school} is committed to supporting children with a parent in prison so that they can continue and succeed with their education.

There are also a number of other national charities and organisations that can offer advice and support for children and families of someone in prison.

School can offer children of prisoners a stable environment where routines and staff generally remain the same at a time when their personal life could be one of change and uncertainty. All school staff are experienced in keeping confidential information about their pupils and will support children in order for them to achieve the best that they can at during their time at our school.

Therefore, it is advisable to inform the head teacher or other member of staff that you know, if a parent or relative of one of our pupils is in prison. It may be that you can arrange a meeting to discuss ways that your child can be supported. This support could range from staff monitoring your child to offering more individual support with open discussion and support about their parent or relative in prison.

Once you have informed a member of staff, we may suggest additional support that can be obtained through an early help assessment process. This is commonly known as ‘EHA’ which stands for ‘Early Help Assessment’. If you agree to this assessment being completed you can state which agencies you are prepared to share the assessment information with, so you are in control of who has access to the information. An ‘EHA’ may identify additional support for you or your family.

As a school we have to monitor the attendance and punctuality of all pupils. Please inform the school of any absence in advance so that consideration may be given to classifying the absence as an ‘authorised absence.’ Working with the school on attendance may avoid the risk of incurring any fixed penalty fines for your child’s absence from school.

In summary

* The education of a child with a parent or relative in prison can be disrupted
* Advice from experts is for families to tell the children the truth about their parent or relative being in prison
* Life for the children and family following the parent being sent to prison could change radically
* All staff and governors of {name of school} are committed to supporting children with a parent or relative in prison
* Informing a member of staff at our school that you have a relative in prison will help the child as we will be able to offer appropriate support and monitor your child’s education and attendance
* We will treat this information in confidence
* Staff of our school will work with you to find the best ways to support your child
* An ‘EHA’ may be suggested as a way to get extra support tailored for your family’s needs. You control who shares in this information

**Parents**

**1. Introduction**

This practice guidance aims to assist all agencies working with children; adults who are parents/carers or with pregnant women and their partners in identifying situations where action is needed to safeguard a child or promote their welfare as a result of an adult’s mental ill health.

The mental health of a parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) does not necessarily have an adverse impact on a child, but it is essential to assess the implications for the child. Just as there is a range in severity of illness, there is also a range of potential impact on families. The majority of parents with a history of mental ill health present no risk to their children, however even in cases of low-level concerns; the needs of the children should be paramount.

It is important to recognise other issues that can exacerbate the risk presented by mental health issues. For example; the presence of drug or alcohol dependency and [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/) in addition to mental health problems with little or no family or community support would indicate an increased likelihood of risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child, and to the parents’ mental health and [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/). Relying on a diagnosis is not sufficient to assess levels of risk. This requires an assessment of every individual’s level of impairment and the impact on the family.

It is essential that the diagnosis of a parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s mental health is not seen as defining the level of risk. Similarly, the absence of a diagnosis does not equate to there being little or no risk. An assessment should consider the impact on the child of behaviour and support services.

**2. Key Definitions**

‘Parent’ may refer to biological and non-biological parents or carers including grandparents, pregnant women and their partners and any adult who has regular responsibility for the care of a child or young person (this may not necessarily mean that the adult in this context has Parental Responsibility in legal terms).

The term “mental ill health” is used to cover a wide range of conditions, from eating disorders, mild depression and anxiety to psychotic illnesses such as schizophrenia or bipolar disorder.

Information about some of the most common conditions can be accessed here:

[**https://www.mind.org.uk/information-support/types-of-mental-health-problems**](https://www.mind.org.uk/information-support/types-of-mental-health-problems)

[**https://www.rcpsych.ac.uk/mental-health/problems-disorders**](https://www.rcpsych.ac.uk/mental-health/problems-disorders)

**3. Responding to Concerns**

The most effective response to children and families affected by mental ill health comes through all agencies adopting a holistic whole family approach. This is based on coordinating the support provided by adult and children’s services to a single family “at risk” in order to secure better outcomes for the children and adults through the use of targeted, specialised and whole family approaches to addressing family needs.

**3.1** Fundamental to this approach is good inter-agency practice characterised by:

* **Routine enquiry**
* **Robust inter-agency communication and information sharing**
* **Joint assessment of need**
* **Joint planning; and action in partnership with the family**
* **Early Help Assessment (EHA) processes should support this and, where necessary, Child in Need and Child Protection Assessment and planning processes**

In any situation where there is a perceived conflict between the interests of the adult and those of the child, all agencies must treat the child’s needs and safety as paramount.

**3.2** Most children with additional needs due to an adult’s mental ill health are considered under the EHA processes and without the intervention of Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

[**https://www.peterborough.gov.uk/healthcare/professionals-area/early-help/the-early-help-approach-in-peterborough/**](https://www.peterborough.gov.uk/healthcare/professionals-area/early-help/the-early-help-approach-in-peterborough/)

[**https://www.cambridgeshire.gov.uk/residents/children-and-families/parenting-and-family-support/providing-children-and-family-services-how-we-work/**](https://www.cambridgeshire.gov.uk/residents/children-and-families/parenting-and-family-support/providing-children-and-family-services-how-we-work/)

However, all agencies must be alert to the potential risks to children of parental mental ill health and must consider its impact on the safety and well being of the children and the need for specialist assessment, consulting other agencies as necessary.

If any agency has concerns that a child is at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) because of the impact of the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s mental health they should check to see if the child is subject to a Child Protection Plan.

**3.3** The Children [Effective Support for Children and Families in Peterborough and Cambridgeshire (Thresholds) Document](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/threshold-document/) Nov 2018 should be used to assess the level of support or need for specialist referral on a case to case basis.

Full details about Early Help and access to [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), including processes and contact details are contained within this.

If an EHA is required, professionals should seek the parent’s/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) and follow the EHA process.

Professionals should follow their own agency’s safeguarding procedures. They should consult their line manager or agency safeguarding lead if they are uncertain about the need to refer to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

Throughout their involvement with the adult and children, professionals must continually review the impact of mental ill health on parenting capacity and the safety and well being of the children.

**4. Children are at greatest risk when:**

* **The child features within parental delusions.**
* **The child becomes the focus of the parent’s aggression.**

In these circumstances the child should be considered at immediate risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and a referral made to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) Services in accordance with the Referrals Procedure.

If you have a concern regarding a child or young person and would like to discuss it further, you should consult the Safeguarding Lead or a Safeguarding Professional within your organisation.

If at any time you have reasonable concern that a child or young person has suffered significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or may be at immediate risk of suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), please contact children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/):

|  |  |  |
| --- | --- | --- |
| **Cambridgeshire**  Telephone 0345 045 5203 | **Peterborough**  (01733) 864180 | [**Emergency Duty Team**](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/)  (01733) 234724 |

**or contact the**[**Police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)**if you feel the child is at imminent risk.**

You should then complete this form to confirm your referral within 24 hours of your telephone call.

[**Safeguarding-Children-Referral-Form**](https://www.safeguardingcambspeterborough.org.uk/concerned/)

**4.1** Where it is believed that a child of a parent with mental health problems may be suffering or likely to suffer Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/); a Strategy Discussion/Meeting should be held and consideration should be given to undertaking a Section 47 Enquiry.

**4.2** In circumstances whereby a parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) has mental health problems it is likely there will be a number of professionals involved from different services. It is important that these professionals work together within enquiries and assessments to identify any links between the parent’s mental health, their parenting, and the impact on the child. Any assessment should include an understanding of the needs of the family and children and an identification of the services required to meet these needs (see appendices for contact details within organisations).

**5. Implications of Parent/Carer Mental Health Difficulty**

Any professional undertaking an assessment needs to consider the following questions to determine how a parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s mental problem may impact on their parenting ability and the child’s development:

* Is there a child or young person living in or visiting the household regularly? If so, does the child/young person take on roles and responsibilities within the home that provide physical or emotional care or support that is inappropriate, excessive or harmful to their health, education or overall development?
* Does the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) neglect their own and their child’s physical and emotional needs?
* Does the mental health problem result in chaotic structures within the home with regard to meal and bedtimes, etc?
* Does the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s mental health have implications for the child within school and attending health appointments etc?
* Is there a lack of the recognition of safety for the child?
* Does the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) have an appropriate understanding of their mental health problem and its impact on their parenting capacity and on their child?
* Are there repeated incidents of hospitalisation for the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) or other occasions of separation from the child?
* Does the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) misuse alcohol or other substances?
* Does the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) feel the child is responsible in some way for their mental health problem?
* Is the child included within any delusions of the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)?
* Does the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s mental health problem result in them rejecting or being unavailable to the child?
* Does the child witness acts of violence or is the child subject to violence?
* Does the wider family understand the mental health problem of the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/), and the impact of this on the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s ability to meet the child’s needs?
* Is the wider family able and willing to support the parent so that the child’s needs are met, and inappropriate, excessive or harmful caring activities are prevented or removed?
* Does culture, ethnicity, religion or any other factor relating to the family have implications on their understanding of mental health problems and the potential impact on the child?
* How the family functions, including conflict, potential family break up etc.

**6. Guidelines for Joint Working**

**6.1** Adult mental health services are provided by CPFT. In office hours you can seek advice from a central source (CPFT safeguarding duty team 01733 777961 CPFT Safeguarding Children (NHSMail) [CPM-tr.cpftsafeguardingchildren@nhs.net](mailto:CPM-tr.cpftsafeguardingchildren@nhs.net)).  Out of hours, please contact CPFT First Response service (FRS). Professional line is 01480 442007

**6.2** 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](https://www.safeguardingcambspeterborough.org.uk/glossary/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](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/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.

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. In CPFT the use of alerts and completed ‘Keeping Children safe Tool’ is promoted in all service users.

**6.3** Mental health practitioners should refer to Royal College of Psychiatrists policy documents, including:

[**Parents as patients – supporting the needs of patients who are parents and their children**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/11/Parents-as-patients-supporting-the-needs-of-patients-who-are-parents-and-their-children.pdf)

[**Social Care Institute for Excellence Guide 30 Think child, think parent, think family: a guide to parental mental health and child welfare**](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/11/SCIE-Parental-mental-health-and-child-welfare.pdf)

The Royal College of Psychiatrists  has also  written guidance around **‘Parental mental illness: the impact on children and adolescents: for parents and carers, 2017’**<https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/parental-mental-illness-the-impact-on-children-and-adolescents-for-parents-and-carers>

**6.4** Close collaboration and liaison between adult mental health services and children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) services are essential in the interests of children. It is similarly important that adult mental health services liaise with other health providers, such as health visitors and general practitioners.

This may need to start before the birth of the child e.g. where there are concerns around parental mental health and potential impacts on unborn child <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/pre-birth_assessment/>

This may require sharing information to safeguard and promote the welfare of children or to protect a child from Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/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.

**6.5** Joint work will include mental health workers providing all information concerning:

* **Treatment plans.**
* **Likely duration of any mental health problem.**
* **Effects of any mental health problem and medication on the**[**carer**](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)**’s general functioning and parenting ability.**

**6.6** Child protection workers must assess the individual needs of each child and within this incorporate information provided by mental health workers. Within Peterborough this is promoted further by the Family Safeguarding model; this will be further implemented across Cambridgeshire.

**6.7** Mental health professionals must attend / provide information to any meeting concerning the implications of the parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)’s mental health difficulty on the child. These will include:

* **Strategy Meetings.**
* **Initial and Review Child Protection Conferences.**
* **Core Groups.**

If there are difficulties obtaining mental health involvement please contact CPFT safeguarding duty team 01733 777961 CPFT Safeguarding Children (NHSMail) [CPM-tr.cpftsafeguardingchildren@nhs.net](mailto:CPM-tr.cpftsafeguardingchildren@nhs.net)  .

**6.8** All plans for a child including Child Protection Plans will identify the roles and responsibilities of mental health and other professionals. The plan will also identify the process of communication and liaison between professionals. All professionals should work in accordance with their own agency procedures / guidelines and seek advice and guidance from line management when necessary.

**6.9** Effective working together depends on an open approach and honest relationships between agencies. Problem solving and resolution is an integral part of professional co-operation and joint working to safeguard children and young people. Where there are difficulties please access <http://www.safeguardingpeterborough.org.uk/childrenboard/professionals/procedures/escalation_policy/>

**7. Contingency Planning**

**7.1** Childcare and mental health professionals should always consider the future management of a change in circumstances for a parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) and the child and how concerns will be identified and communicated. This may include:

* **Relapse in the parent/**[**carer**](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)**’s mental health.**
* **Failure to maintain medication.**
* **Change in family dynamics/relationships.**

**7.2** Professionals need to carefully consider the implications for children when closing their involvement with parents with a mental health problem. Consideration should be given to informing the appropriate Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) Services team in order that the implications for the child are assessed.

**7.3** In cases of significant risk, professionals can request a multi agency risk management meeting. Please contact the named nurse via CPFT safeguarding duty team 01733 777961 CPFT Safeguarding Children (NHSMail) [CPM-tr.cpftsafeguardingchildren@nhs.net](mailto:CPM-tr.cpftsafeguardingchildren@nhs.net)

**8. Learning lessons nationally from Serious Case Reviews**

[**https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/parents-mental-health-problem/**](https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/parents-mental-health-problem/)

[**https://learning.nspcc.org.uk/children-and-families-at-risk/parental-mental-health-problems/**](https://learning.nspcc.org.uk/children-and-families-at-risk/parental-mental-health-problems/)

**Young Carers Support**

A young [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) is a young person, under the age of 18, who has a caring responsibility. This is usually for a family member who has a disability, long-term illness, mental illness (including depression, anxieties) or drug/alcohol substance misuse. <https://cambridgeshirecin.proceduresonline.com/chapters/p_young_carers.html>

Support can be accessed via:

* **Caring Together – St Ives office T 0345 241 0954 or 01480 499090 Email**[**hello@caringtogether.org**](mailto:hello@caringtogether.org)
* [**https://www.caringtogether.org/support-for-carers/young-people/young-carers**](https://www.caringtogether.org/support-for-carers/young-people/young-carers)
* [**https://www.cambridgeshire.gov.uk/residents/children-and-families/parenting-and-family-support/supporting-young-carers/**](https://www.cambridgeshire.gov.uk/residents/children-and-families/parenting-and-family-support/supporting-young-carers/)
* [**http://centre33.org.uk/help/young-carer-project/**](http://centre33.org.uk/help/young-carer-project/)

**Background information about Diagnosis and Treatments**

Mental health diagnosis can not be seen in isolation. We must see the parent who has mental health needs in a holistic way.

However, some practitioners have indicated that they would like more information. The following sites provide reputable information.

**Drugs and treatments**

[**https://www.mind.org.uk/information-support/drugs-and-treatments/**](https://www.mind.org.uk/information-support/drugs-and-treatments/)

[**https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing**](https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing)

**Appendix 1**

**Key Contacts within Cambridge and Peterborough Partnership**

**1. Early Help pathways.**

Peterborough Early Help Team for advice on how to proceed email [earlyhelp@peterborough.gov.uk](mailto:earlyhelp@peterborough.gov.uk)  or Telephone 01733 863649

Cambridgeshire-  email [early.helphub@cambridgeshire.gov.uk](mailto:early.helphub@cambridgeshire.gov.uk)  or Telephone on 01480 376 6661

**2. Children Social Care Assessment**

If there is reasonable concern that a child or young person has suffered significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or may be at immediate risk of suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) contact:

|  |  |  |
| --- | --- | --- |
| **Cambridgeshire** | **Peterborough** | [**Emergency Duty Team**](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/) |
| 0345 045 5203 | (01733) 864180 | (01733) 234724 |

**or contact the**[**Police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)**if you feel the child is at imminent risk.**

Follow all telephone referrals in writing within 24 hours email to [ReferralCentre.Children@cambridgeshire.gov.uk](mailto:ReferralCentre.Children@cambridgeshire.gov.uk)

**3. Mental Health Professional Concerns**

* Urgent mental health advice/assessment needed contact: professional line 01480 442007 (111 option 2 for patients) 24 hours a day 365 days a year.
* Non urgent professional enquiries with mental health services, call care co-ordinator for patient if known.
* Otherwise call CPFT safeguarding team 01733 777961 CPFT Safeguarding Children (NHSMail) [CPM-tr.cpftsafeguardingchildren@nhs.net](mailto:CPM-tr.cpftsafeguardingchildren@nhs.net)or First Response Service  NHS 111 Option 2  
  Telephone:  01480 442 007 (professionals line) [firstresponseservice.frs@cpft.nhs.uk](mailto:firstresponseservice.frs@cpft.nhs.uk)  (team email)

**4. Other useful CPFT mental health numbers are :-**

* Parental mental health for > 17 year olds via GP go to Primary Care Mental Health Service Telephone: 01733 748777
* Perinatal Mental Health Services <https://www.cpft.nhs.uk/services/specialist-community-perinatal-mental-health-service.htm>  
  The team is operational 9am – 5pm, Monday to Friday. You can contact the team on 0800 952 0060 (Mon to Fri, 9am-5pm) or [PerinatalReferrals@cpft.nhs.uk](mailto:PerinatalReferrals@cpft.nhs.uk).
* Parents under 17 years old- Single Point of Access, Community CAMHS Team Telephone: 01480 428115 Fax: 01480 428149 or Email [accesscamhs@nhs.net](mailto:accesscamhs@nhs.net)
* Primary Care Mental Health Service promote early assessment, treatment and/or onward referral in the community for assessment via GPs  
  Telephone 01733 748777 or email [cpm-tr.prismservice@nhs.net](mailto:cpm-tr.prismservice@nhs.net).

**5. Police contacts**

contact numbers 101 (Integrated [Mental Health Team](https://www.safeguardingcambspeterborough.org.uk/glossary/mental-health-team/)). 0700-20.00hrs

[Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) Multi-agency Safeguarding Hub 01480 847743

Out of hours contact 01733 234724.

**6. Unborn baby pathway**

Pre-Birth Protocol <http://www.safeguardingcambspeterborough.org.uk/childrenboard/professionals/procedures/pre-birth_assessment/>

**7. Perinatal mothers presenting with psychosis assess via perinatal team**

Telephone: 0800 952 0060 (Mon to Fri, 9am-5pm) or [PerinatalReferrals@cpft.nhs.uk](mailto:PerinatalReferrals@cpft.nhs.uk)

**8. City & South Cambridgeshire Learning Disability Partnership**

Comberton Road, Cambridge CB23 2RY Telephone: 01223 743747

**9. Mental Health Act assessments /Approved Mental Health Professional office**

Telephone**:**0345 245 0067

Cambridge Adult [Mental Health Team](https://www.safeguardingcambspeterborough.org.uk/glossary/mental-health-team/) Telephone: 01223 341500

**10. Midwifery specialist Named Midwives**

**Peterborough and Hunts**

Karen Hedger: Named Midwife for Safeguarding, Peterborough City Hospital.

Telephone: 01733 673775 / 07802656033 Email: khedger@nhs.net

**Cambridgeshire**

|  |  |
| --- | --- |
| Jo Bellamy (Mon-Tuesday) | Toni Van Vorst (Wed-Friday) |
| Tel: 01223 348988 Ext:348988  Email [joanna.bellamy@addenbrookes.nhs.uk](mailto:joanna.bellamy@addenbrookes.nhs.uk) or secure email for confidential information [joanna.bellamy@nhs.net](mailto:joanna.bellamy@nhs.net) | Tel : 01223 256932  Mobile: 07740753920 Email [toni.vanvoorst@addenbrookes.nhs.uk](mailto:toni.vanvoorst@addenbrookes.nhs.uk) or secure email for confidential information: [toni.vanvoorst@nhs.net](mailto:toni.vanvoorst@nhs.net) |

**11. Out Of Hours Mental Capacity assessments via First Response Service**

Tel:  01480 442 007 (Professionals line)

Email: [firstresponseservice.frs@cpft.nhs.uk](mailto:firstresponseservice.frs@cpft.nhs.uk)

**12. Adult Mental Health Teams see contacts below appendix 2**

**Appendix  2  CPFT Adult mental health services**

Click on blue coloured hyperlink for service details

The pathways that CPFT provides are listed below. For more information on the teams that deliver these pathways please click on the links on the left-hand side of the page.

|  |  |  |  |
| --- | --- | --- | --- |
| **Pathway** | **Disorder** | **Treatments available** | **Teams supporting the pathway** |
| Affective Disorders | * Bipolar affective disorder * Depression * Anxiety * Obsessive compulsive disorder * Post-traumatic stress disorder | * Assessment and initial treatment advice * Care plan developed with service user * Pharmacological interventions and medication management * Psychological therapies, mainly CBT, aimed at the specific disorder * Support for carers and families * Regular care plan reviews * Information and support with employment and activities of daily living * Advice on health and [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) * Crisis planning * Relapse plan | **Community teams:**   * [Cambridge locality team](https://www.cpft.nhs.uk/services/cambridge-adult-locality-team.htm) * [Fenland locality team](https://www.cpft.nhs.uk/services/fenland-team.htm) * [Huntingdon Locality Team](https://www.cpft.nhs.uk/services/huntingdon-adult-team.htm) * [Peterborough Locality Team](https://www.cpft.nhs.uk/services/peterborough-adult-locality-team.htm) * [Psychological Wellbeing Service](https://www.cpft.nhs.uk/services/pws/psychological-wellbeing-service.htm) |
| Early intervention (CAMEO) pathway | * Psychosis | * Help, advice, support and signposting * Focused specialist interventions including: * Cognitive behavioural therapy * Relapse prevention * Low-dose medication * Recovery formulation * Help to get back to work, college or develop social life * Family work * Support groups * Structured measures of symptoms and functioning * Two-year follow-up – continuous clinical assessment | **Community team:**   * [Cameo – Early intervention service](https://www.cpft.nhs.uk/services/cameo---early-intervention-service.htm) |
| Psychosis | * Schizophrenia * Schizo-affective disorder * Psychotic illness * Dual diagnosis/psychotic illness * Dual diagnosis where psychotic illness is the primary condition * Bipolar affective disorder with psychosis * Delusional disorder * Bipolar affective disorder with psychosis * Psychotic depression | * Assessment and initial treatment advice * Care plan developed with service user * Pharmacological interventions and medication management * Psychological therapies, mainly CBT, aimed at the specific disorder * Support for carers and families * Behavioural family therapy * Regular care plan reviews * Information and support with employment and activities of daily living * Advice on health and [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) * Crisis planning * Relapse plan | **Community teams:**   * [Cambridge locality team](https://www.cpft.nhs.uk/services/cambridge-adult-locality-team.htm) * [Fenland locality team](https://www.cpft.nhs.uk/services/fenland-team.htm) * [Huntingdon Locality Team](https://www.cpft.nhs.uk/services/huntingdon-adult-team.htm) * [Peterborough Adult Locality Team](https://www.cpft.nhs.uk/services/peterborough-adult-locality-team.htm) |
| Acute and psychiatric intensive care pathway including crisis resolution and home treatment | * Adults with severe mental illness/disorder experiencing an acute episode or in crisis. | * Multi-disciplinary * Medical/physical assessment * Medication * Person-centred approach * Ward-based programme of therapeutic activities * Psychosocial interventions * Aid to daily living support * Discharge planning * Home treatment and home visits in line with care plans. | **Community teams:**   * [Crisis resolution and home treatment team, Cambridge](https://www.cpft.nhs.uk/services/Crisis%20Resolution%20Home%20Treatment%20Team%20south) * [Crisis resolution and home treatment team, Peterborough and Huntingdon](https://www.cpft.nhs.uk/services/Crisis%20Resolution%20Home%20Treatment%20Team%20north)   **In-patient units:**   * [Mulberry 1](https://www.cpft.nhs.uk/services/mulberry-1.htm), [Mulberry 2](https://www.cpft.nhs.uk/services/mulberry2.htm) and [Mulberry 3 wards](https://www.cpft.nhs.uk/services/mulberry-3.htm), Cambridge * [Treatment](https://www.cpft.nhs.uk/services/treatment-ward) ward,  [Acute assessment Unit](https://www.cpft.nhs.uk/services/acute-assessment-unit.htm), and [Recovery Unit](https://www.cpft.nhs.uk/services/Oak4.htm)Peterborough * [George Mackenzie House, Cambridge](https://www.cpft.nhs.uk/services/george-mackenzie-house.htm) * [Poplar (Psychiatric intensive care unit – PICU)](https://www.cpft.nhs.uk/services/poplar-psychiatric-intensive-unit)Peterborough * [Springbank ward (for women with personality disorders)](https://www.cpft.nhs.uk/Springbank/) |
| Personality disorders pathway | * Personality disorder | * Assessment and treatment advice * Help, advice, support and signposting * Risk assessment, formulation and management * Care plan developed with service user * Daily crisis support * Medication review and management * Psychoeducation * Time-limited specialist interventions including: * Metallisation-based group therapy * MOHO-based goal setting group * DBT-based interventions for emotion regulation and distress tolerance * Relapse planning | **Community team:**   * [Personality disorders community service team](https://www.cpft.nhs.uk/services/personality-disorders-community-team.htm) |
| Eating disorders | * Anorexia nervosa * Bulimia nervosa * Binge-eating disorder * Eating disorder not otherwise specified | * Psychological/psychiatric * Medical assessment * Nutritional rehabilitation * Range of psychological therapies * Family counselling * Family workshops/couples’ work * Carers’ assessment * Community psychological therapy programme * Carers’ support group | **Community teams:**   * [Cambridge, Peterborough, and Norfolk  Adult Eating Disorders service](https://www.cpft.nhs.uk/aeds)   **In-patient unit:**   * [S3 ward, Addenbrookes](https://www.cpft.nhs.uk/services/ward-environment.htm) |

The page was last updated on 31 October 2018 by agrosbois.

**Appendix 3 Understanding CPFT Front Door Services**

**1. First Response Service (emergency Front door)**

What to do in a mental health crisis <https://www.cpft.nhs.uk/about-us/help-in-a-crisis.htm>

Call 111 and press option 2 for the First Response Service – a 24-hour service for people in a mental health crisis. This service is for anyone, of any age, who is registered with a GP in Cambridgeshire or Peterborough. Specially-trained mental health staff will speak to you and discuss with you your mental health care needs – instead of you having to go to accident and emergency departments of local acute hospitals.

Professionals number 01480 442007

If living in Wisbech please call 111, select option 1 and then ask the call handler to put you through the First Response Service.

Signs you might be in crisis if:

* You are thinking of hurting yourself or suicide seems the only option
* Someone you know has made threats to hurt you or someone else.
* You are experiencing extreme distress that seems overwhelming.

**2. Front Door (non-urgent**) Between 9am-5pm, Monday–Friday

1. CPFT Care Co-ordinator: If you are already receiving support from CPFT services, the first point of contact should be your care co-ordinator or named nurse. Your care plan will contain information on how to contact them. If they are not available, ask to speak to the clinician on duty. Professionals who are unsure what service is used can contact CPFT safeguarding team 01733 777961 or FRS 01480 442007. (out of office hours)
2. Your GP: If you need immediate help, then please contact your GP.
3. The Primary Care Mental Health Service promotes early assessment, treatment and/or onward referral in the community. It supports patients to focus on achievable goals and access local community resources.  
   The service promotes a patient-centred joint approach to physical and mental health, and support patients to step down from specialist mental health services. Patients’ [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) needs are also considered as part of this integrated approach.  
   The Primary Care Mental Health Service is for anyone aged between 17-65 years with mental ill health and is based on a person’s needs rather than their diagnosis. Based on need, they may be referred on to different health services, such as specialist mental health services, including the First Response Service.  
   **The patient sees their GP and a decision is made as to which service would be appropriate for the patient – this could be a referral to the Primary Care Mental Health Service team.**Once referred, service staff will contact the patient / service user and either provide telephone advice and signposting or offer a face-to-face assessment.  
   Patients will meet Primary Care Mental Health Service staff in their local GP surgery,  
   If you would like further information, please contact 01733 748777 or cpm-tr.prismservice@nhs.net.
4. **For parents under 17 years front door to mental health services is via:**Single Point of Access, Community CAMH Team; Newtown Centre, Nursery Road, Huntingdon PE29 3RJ. Single Point of Access – CAMHS Telephone: 01480 428115 Fax: 01480 428149. email address:  [accesscamhs@nhs.net](mailto:accesscamhs@nhs.net)
5. For professional advice which about which service is working with a patient or if you feel mental health services would benefit from working more closely with other professionals: Call **CPFT safeguarding duty team 01733 777961 CPFT Safeguarding Children (NHSMail)**[**CPM-tr.cpftsafeguardingchildren@nhs.net**](mailto:CPM-tr.cpftsafeguardingchildren@nhs.net)**.**

**Appendix 4  – Links to other related Local guidance and policy**

**Cambridgeshire and Peterborough Information Sharing Agreement** <https://www.cambridgeshire.gov.uk/asset-library/imported-assets/CandP%20ISF%20V2.5%20July%202019.pdf>

**Pre-Birth Protocol** [http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/pre-birth\_assessment/](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/pre-birth_assessment/)

**Domestic Violence and**[**Abuse**](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)**Procedure** <https://cambridgeshirecin.proceduresonline.com/chapters/p_dom_viol_abuse.html>

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/domestic-violence-and-abuse/>

**Childrens**[**Social Care**](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)**Assessment process**<http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-and-family-assessment/>

<http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/03/child-and-family-single-assessment-framework-Cambs.pdf>

**Working with Uncooperative or Hostile Parents**<http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/noncompliant/>

**Children of Parents who Misuse Substances Procedure** <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/children-of-parents-who-misuse-substances/>

**Children Visiting Psychiatric Wards and Special Hospitals** <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/children-visiting-psychiatric-wards-and-special-hospitals/>

[**Police**](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)**and mental health**  <https://www.app.college.police.uk/app-content/mental-health/>

**Multi-Agency Parenting Skills Assessment** <http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/03/mapsa.pdf>

**Appendix 5**

**What does research tell us about the needs and experiences of families, in contact with**[**social care**](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)**, where at least one parent has learning disabilities?**

Almost all the information we have about parents with learning disabilities concerns those who are in contact with [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), and it mostly concerns mothers. We know very little about the needs and experiences of families where at least one parent has learning disabilities but who are not in contact with [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/); and we currently know very little about the experiences of fathers with learning disabilities, although research is now being undertaken in this area.

Estimates of the total number of parents with learning disabilities in the United Kingdom vary widely, from 23,000 to 250,000. What is clear, however, is that there are increasing numbers of parents with learning disabilities in contact with services. Over the last decade or so, clinical psychologists have reported an increase in requests for assessments, and community learning disability teams have seen an increase in the number of parents with learning disabilities on their caseloads. Most children and family teams have at least one family affected by parental learning disability on their caseloads (Booth and Booth, 2005).

There are also varying estimates of the proportion of parents whose children are removed from their care. It would appear, from a national survey of people with learning disabilities, that about 40% of parents are not living with their children. They are more likely to be living with their children if they are living with other relatives (particularly in the case of mothers), and fathers are more likely to be living with their children than mothers. Six out of ten mothers, who live either on their own or with a partner, are not living with their children aged under 18.

In one local authority area, about a sixth of family court care proceedings concerned children with at least one parent who has learning disabilities and in about 75% of cases children were permanently removed from their family (Booth et al, 2005).

However, analysis of case files across 10 local authority areas found that in less than a fifth of cases involving parents with learning disabilities where their children were removed, most were fostered rather than adopted, and there ‘was no [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to suggest that parental learning disability in itself was the reason children were removed’ (Cleaver and Nicholson, 2007).

There is anecdotal [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of local variations in [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) practice and court decisions.

Most parents with learning disabilities in contact with [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) experience a range of difficulties. Parents with learning disabilities, who are in contact with [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) often experience poverty, unemployment, poor housing, difficult neighbourhoods and lack of information ([Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) Institute for Excellence, 2005). While these are factors experienced by most families in contact with children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/); parents with learning disabilities have particularly high levels of need, often experiencing severe poverty and inadequate housing (Cleaver and Nicholson, 2007).

Moreover, the lack of information experienced by poor families generally is compounded for parents with learning disabilities by the inaccessibility of most forms of information. Research on parenting support generally, finds that it is very difficult for stressed families to benefit from such support when they face disadvantages such as poverty, poor health and difficult housing situations (Moran et al, 2004). [Social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) services, therefore, often need to work with other agencies to attempt to, for example, improve a family’s housing situation.

Families affected by parental learning disability are also particularly likely to experience negative attitudes from those with whom they come into contact. For example, small scale studies (e.g. Cooke 2005) and messages from parents with learning disabilities themselves (e.g. CHANGE 2005) indicate that harassment and bullying, and sometimes violence and financial or sexual exploitation can be a major problem for parents with learning disabilities and their children.

Most parents with learning disabilities who receive core assessments from children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) also experience other difficulties such as ‘poor mental and physical health, domestic violence, growing up in care, or substance misuse’ (Cleaver and Nicholson, 2007).

Parents with learning disabilities may also have low self-esteem and lack confidence, primarily because of previous experiences of discrimination, [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)and segregation. People with learning disabilities are more likely to have experienced physical, emotional or sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) as children and young adults and will carry the legacies of these experiences into their own parenting experiences.

Some professionals have raised concerns that parents with learning disabilities experience undiagnosed mental health problems including: post-natal depression and argued that it is important to diagnose and respond to such needs (Cotson et al, 2001)

Professionals consulted for this guidance raised their concerns that physical health problems experienced by parents with learning disabilities are also sometimes undiagnosed.

The presence or absence of social support would seem to be more important than the presence or absence of learning disability in terms of the implications for parenting capacity. Social support and stress are negatively correlated amongst mothers with learning disabilities ‘suggesting that the former may buffer the adverse effects of the latter’ (Feldman et al, 2002).

The larger more recent and more helpful the support network reported by mothers with learning disabilities; the better their psychological [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) and the greater likelihood of positive parenting experiences (Kroese, et al, 2002).

Learning disability may also mean that a parent has some specific support needs relating to their impairment.

There is no clear relationship between IQ and parenting, unless it is less than 60 (McGaw and Newman, 2005). Although IQ is not a good indicator of parenting capacity, cognitive impairment may mean that a parent has difficulty with reading and writing, remembering and understanding, decision-making and problem-solving, and this will create particular support needs for parenting. Indeed, most parents with these difficulties recognise that they need practical support and help with learning about childcare (Tarleton et al, 2006). Parents who came to a National Gathering of parents with learning disabilities emphasised, for example, that they need information in accessible formats:

“The information given to parents in booklets like ‘Birth to 5’6 is not accessible to parents with learning disabilities. We need information in pictures, plain English, and on tape” (CHANGE, 2005, p.17).

Parents’ learning disability can also impact on their children’s development for example; their own language difficulties may inhibit their ability to stimulate their children’s language development. This may mean they need advice about verbal interaction with children and/or additional support to children to help with language development (Cotson et al, 2001).

Children’s experiences

We know very little about the experiences of children of parents with learning disabilities, other than that which concerns their parents’ experiences of children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and the child protection system. A study of assessments of families affected by parental learning disability found that half the children had severe developmental needs and two-thirds were experiencing family and environmental disadvantages (Cleaver and Nicholson, 2007).

One study interviewed 30 adult children of parents with learning disabilities about their experiences of childhood and adulthood. These were children who remained with their families and no comparison was made with children taken into alternative care. Four themes emerged from the interviews:

* More attention needs to be paid to the protective factors which promote resilience amongst children and which “shield them from the potentially harmful effects of parenting deficits”
* Families affected by parental learning disability are also particularly likely to experience negative attitudes, and worse, from those with whom they come into contact. For example; small scale studies (e.g. Cooke 2005) and messages from parents with learning disabilities themselves (e.g. CHANGE 2005) indicate that harassment, bullying and sometimes violence, financial or sexual exploitation, can be a major problem for parents with learning disabilities and their children.
* Most parents with learning disabilities who receive core assessments from children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) also experience other difficulties such as “poor mental and physical health, domestic violence, growing up in care, or substance misuse” (Cleaver and Nicholson, 2007).
* Parents with learning disabilities may also have low self-esteem and lack confidence, primarily because of previous experiences of discrimination, [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and segregation. People with learning disabilities are more likely to have experienced physical, emotional or sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) as children and young adults, and will carry the legacies of these experiences into their own parenting experiences.

Some professionals have raised concerns that parents with learning disabilities experience undiagnosed mental health problems including post-natal depression, and argued that it is important to diagnose and respond to such needs (Cotson et al, 2001).

Professionals consulted for this guidance raised their concerns that physical health problems experienced by parents with learning disabilities are also sometimes undiagnosed.

The presence or absence of social support would seem to be more important than the presence or absence of learning disability in terms of the implications for parenting capacity. Social support and stress are negatively correlated amongst mothers with learning disabilities ‘suggesting that the former may buffer the adverse effects of the latter’ (Feldman et al, 2002). The larger, more recent and more helpful the support network reported by mothers with learning disabilities, the better their psychological [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) and the greater likelihood of positive parenting experiences (Kroese, et al, 2002). This and other quotes from parents with learning disabilities, come from meetings held with parents as part of putting together this good practice guidance.

**Responding to concerns about a child**

Anyone who has concerns about a child’s welfare should make a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and should do so immediately if there is a concern that the child is suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or is likely to do so. This includes professionals who work with children and their families but could also be the child themselves, family members or members of the public. Practitioners who make a referral should always follow up their concerns if they are not satisfied with the response.

The Children Act 1989 introduced the concept of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) as the threshold which justifies compulsory intervention in family life in the [best interests](https://www.safeguardingcambspeterborough.org.uk/glossary/best-interests/)of children. Section 47 of the Act places a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or is likely to suffer significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

It is therefore important that all professionals working with children and families understand the concept of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and also what constitutes [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect.

**Responding to risks of harm to an unborn child**

In some circumstances, agencies or individuals are able to anticipate where an expected baby is likely to suffer significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) (e.g. domestic violence, parental substance misuse or mental ill health).

These concerns should be addressed as early as possible before the birth so that a full assessment can be undertaken and support offered to enable the parent/s (wherever possible) to provide safe care. For more information, see the [pre-birth procedures](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/pre-birth_assessment/).

**Responsibilities of agencies and organisations**

Each organisation should have internal child protection procedures which are compliant with the Cambridgeshire and Peterborough Safeguarding Children Board’s countywide multi-agency procedures.

Each organisation’s own internal child protection procedures must provide information about how to:

* identify potential or actual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to children
* discuss and record concerns with a first line manager/in supervision
* analyse concerns by completing an assessment
* discuss concerns with the organisation’s designated safeguarding lead (who should be able to offer advice and decide upon the necessity for a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)).

Professionals in all organisations should be sufficiently knowledgeable and competent to contact local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) or the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) about their concerns directly and to complete the appropriate referral form. Where advice is required, professionals should feel comfortable contacting their Safeguarding Lead to discuss the case.

If it appears that the child is suffering, or likely to suffer, significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), a formal referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) or emergency services (for any urgent medical treatment) must not be delayed by the need for consultation with management or the designated safeguarding practitioner lead, or the completion of an assessment.

**Adult Services Responsibilities in Relation to Children**

Adult services and professionals working with adults need to be competent in identifying the service users’ or patient’s role as a parent. They need to be able to consider the impact of the adult’s condition and/or behaviour on:

* A child’s welfare and development;
* Family functioning;
* The adult’s parenting capacity.

Where a professional working with adults has concerns about the parent’s capacity to care for the child and considers that the child is likely to be harmed or is being harmed, they should immediately refer the child to the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) or LA children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), in accordance with their agency’s child protection procedures.

Requests for information about a child, which are often made to health professionals such as GPs or specialist services for mental health or substance misuse, by LA children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should be directed to the correct professional and not dealt with by administrative staff or intermediaries.

Adult Services, whether commissioning and or provider organisations, employ safeguarding children professionals to take the lead on safeguarding children matters. The roles and responsibilities of designated and named safeguarding children professionals should be clear and accessible to all staff and made known to partner agencies to assist in the process of sharing information.

**Schools and Educational Establishments**

One of the main sources of referrals about children is schools, which means all schools whether maintained, non-maintained or independent schools, including academies and free schools, alternative provision academies and pupil referral units. ‘School’ includes maintained nursery schools.

All schools, educational establishments and colleges must have regard to the statutory guidance [Keeping Children Safe in Education](https://www.gov.uk/government/publications/keeping-children-safe-in-education--2) when carrying out their duties to safeguard and promote the welfare of children.

‘Keeping children safe in education’ contains information on what schools and colleges should do and sets out the legal duties with which schools and colleges must comply. It should be read alongside the statutory guidance ‘Working Together to Safeguard Children’ 2018, which applies to all the schools referred to above, and departmental advice [‘What to do if you are worried a child is being abused: Advice for Practitioners’](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf).

All schools and education settings for all age groups should have systems in place to promote the welfare of children and a culture of listening to children taking in to account their views and wishes.

Each establishment must have a designated professional lead for safeguarding. This role should be clearly set out and supported with a regular training and development program in order to fulfil the child welfare and safeguarding responsibilities. Arrangements within each school should set out the processes for sharing information with other professionals and the local LSCB.

All school and college staff have a responsibility to provide a safe environment in which children can learn.

All school and college staff have a responsibility to identify children who may be in need of extra help or who are suffering, or are likely to suffer, significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). All staff then have a responsibility to take appropriate action, working with other services as needed. All school and college staff members should be aware of the signs of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect so that they are able to identify cases of children who may be in need of help or protection. Staff members working with children are advised to maintain an attitude of ‘it could happen here’ where safeguarding is concerned. When concerned about the welfare of a child, staff members should always act in the interests of the child.

In addition to working with the designated safeguarding lead, staff members should be aware that they may be asked to work with social workers to make plans for and take decisions about individual children.

All educational establishments and colleges must have safe recruitment policies and procedures in place.

Clear policies and procedures in accordance with the local LSCB procedures for managing allegations against people who work with children must be in operation in every school or setting (see [Allegations Against Staff or Volunteers Procedures](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/managingallegations/)

**Responsibilities of professionals**

Professionals in **all** agencies and organisations (including public services, commissioned provider services and voluntary organisations; whether paid or a volunteer) who come into contact with children, who work with adult parents/carers or who gain knowledge about children through working with adults, should:

* be alert to potential indicators of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect
* be alert to the risks which individual abusers, or potential abusers, may pose to children
* be alert to the impact on the child of any concerns of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or maltreatment
* be able to gather and analyse information as part of an assessment of the child’s needs.

The law empowers anyone who has care of a child to do all that is reasonable in the circumstances to safeguard their welfare. Accordingly, professionals in all agencies should take appropriate action wherever necessary to ensure that no child is left in immediate danger, e.g. a teacher, foster [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/), childminder, a volunteer or any professional should take all reasonable steps to offer a child immediate protection (including from an aggressive parent).

Charity trustees are responsible for ensuring that those benefiting from, or working with, their charity, are not harmed in any way through contact with it.

**Duty to co-operate and refer**

All professionals in agencies with contact with children and members of their families must make a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) if there are signs that a child or an unborn baby:

* is suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect
* is likely to suffer significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) in the future.

Professionals who wish to report concerns about a child should complete the online [Safeguarding Children Referral Form](https://www.safeguardingcambspeterborough.org.uk/concerned/professionals-reporting-a-concern/)

All telephone referrals should be confirmed in writing within 24 hours.

* Cambridgeshire Children [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/): 0345 045 5203
* Peterborough Children [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/): 01733 864180

In urgent situations out of office hours the referral should be made to the [emergency duty team](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/) (out of hours) on 01733 234724.

Where a child or unborn baby has an allocated social worker and a professional has new or additional information this must be documented and passed without delay to the allocated social worker or case manager for consideration by children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).  In the event the allocated social worker and/or case manager are unavailable the person holding information should follow the arrangements for passing on information to the relevant team.  As above, if it is outside of office hours the local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) [emergency duty team](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/)/out of hours team should be contacted if the concern is high.  In emergencies, such as if a child is in immediate danger, the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) should be called for assistance.

Local Authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should **within one working day**of receiving the referral make a decision about the type of response that will be required to meet the needs of the child. If this does not occur within three working days, the referrer should contact these services again and, if necessary, ask to speak to a line manager to establish progress.

If practitioners have concerns that a child may be a potential victim of modern slavery or trafficking then a referral should be made to the National Referral Mechanism, as soon as possible

**Hearing and Observing the child**

Whenever a child reports that they are suffering or have suffered significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect, or have caused or are causing physical or sexual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to others, the initial response from all professionals should be limited to listening carefully to what the child says and to observe the child’s behaviour and circumstances to:

* clarify the concerns
* offer re-assurance about how the child will be kept safe
* explain what action will be taken and within what timeframe.

Consideration should be given to additional support or [advocacy](https://www.safeguardingcambspeterborough.org.uk/glossary/advocacy/) for children with communication difficulties or disabilities and those who do not speak English (particularly unaccompanied children, refugees or those trafficked from abroad). The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) investigations, especially in cases of sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

If the child can understand the significance and consequences of making a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), they should be asked their view.

However, it should be explained to the child that, whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child’s safety and the safety of other children.

See also: [**Lived Experience of the Child Practice Guidance**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/lived-experience-of-the-child/)

**Consulting parents**

Where practicable, concerns should be discussed with the parent and agreement sought for a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) unless seeking agreement is likely to:

* place the child at risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) through delay or the parent’s actions or reactions
* lead to the risk of loss of evidential material. For example in circumstances where there are concerns or suspicions that a serious crime such as sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or induced illness has taken place.

Where a professional decides not to seek parental permission before making a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), the decision must be recorded in the child’s file with reasons, dated and signed and confirmed in the referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

A child protection referral from a professional cannot be treated as anonymous, so the parent will ultimately become aware of the identity of the referrer. Where the parent refuses to give permission for the referral, unless it would cause undue delay, further advice should be sought from a manager or the nominated child protection adviser and the outcome fully recorded.

If, having taken full account of the parents’ wishes, it is still considered that there is a need for referral:

* the reason for proceeding without parental agreement must be recorded
* the parent’s withholding of permission must form part of the verbal and written referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)
* the parent should be contacted to inform them that, after considering their wishes, a referral has been made.

**Considering diversity**

At all stages of the child protection process, consideration must be given to issues of diversity, taking into account:

* the impact of cultural expectations and obligations on the family
* the family’s knowledge and understanding of UK law in relation to parenting and child welfare
* the impact on the family if recently arrived in the UK and their immigrant status
* the need to use safe and independent interpreters for discussions about parenting and child welfare, even though the family’s day-to-day English may appear/be adequate.

The analysis of the child’s and families cultural needs must not result in a lowering of expectations when applying standards of good practice to safeguarding the child.

**Seeking urgent medical attention**

If the child is suffering from a serious injury, the professional must seek immediate medical attention from emergency services and must inform local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), and the duty consultant paediatrician at the hospital.

Where [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is alleged, suspected or confirmed in a child admitted to hospital, the child must not be discharged until:

* the local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) for the area where the hospital is located and for the child’s home address are notified by telephone that there are child protection concerns. (This may be two different local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) teams)
* a strategy meeting/discussion has been held, if appropriate, which should include relevant hospital and other professionals.

**Responding to concerns raised by members of the public**

When a member of the public telephones or approaches any agency with concerns, about the welfare of a child or an unborn baby, the professional who receives the contact should always:

* Gather as much information as possible in order to make a judgement about the seriousness of the concerns.
* Take basic details:
* Name, address, gender and date of birth of child
* Name and contact details for parent/s, educational setting (e.g. nursery, school), primary medical practitioner (e.g. GP practice), professionals providing other services, a lead practitioner for the child.
* Discuss the case with their manager and the agency’s designated safeguarding professional lead to decide whether to:
  + make a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)
  + make a referral to the lead practitioner, if the case is open and there is one
  + make a referral to a specialist agency or professional e.g. educational psychology or a speech and language therapist
  + undertake an assessment.
* Record the referral with the detail of information received and given, separating out fact from opinion as far as possible.
* Inform the referrer about what happens next.

The member of the public should also be given the number for their local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and encouraged to contact them directly. The agency receiving the initial concern should **always** make a referral to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) (and to the lead professional if there is one) in case the member of the public does not follow through (a common occurrence).

If there is a risk that the member of the public will disengage without giving sufficient information to enable agencies to investigate concerns about a child, the NSPCC national 24 hour Child Protection Helpline (0808 800 5000) and Childline (0800 1111) can be offered as an alternative means of reporting concerns.

Individuals may prefer not to give their name to local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) or the NSPCC. Alternatively they may disclose their identity, but not wish for it to be revealed to the parent/s of the child concerned. Wherever possible, professionals should respect the referrer’s request for anonymity. However professionals should not give referrers any guarantees of confidentiality as there are certain limited circumstances in which the identity of a referrer may have to be given (e.g. the court arena).

Local publicity material should make the above position clear to potential referrers.

Local authority children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should offer the referrer the opportunity of an interview.

**Safer recruitment**

**1. Definition**

All statutory and public organisations (including non-regulated activity) which employ staff and/or volunteers to work with or provide services for children have a duty to safeguard and promote the children’s welfare. This includes ensuring that safe recruitment and selection procedures are adopted.

Organisations who employ people who work with children, e.g. private or voluntary sector, who do not have access to advice in house or from other sources, may access helpful resources via the [NSPCC safeguarding standards and guidance (England) Safeguarding children, young people and adults aged 0-25 in the voluntary and community sector](https://www.nspcc.org.uk/services-and-resources/research-and-resources/2017/safe-network-standards/?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3D%3D&_t_q=safer+recruitment&_t_tags=language%3Aen%2Csiteid%3A7f1b9313-bf5e-4415-abf6-aaf87298c667&_t_ip=10.99.66.5&_t_hit.id=Nspcc_Web_Models_Pages_ResearchReportsPage/_1a12334f-67ba-4710-a60c-87b50afc2b0e_en-GB&_t_hit.pos=20)

This procedure identifies good practice in safer recruitment and selection and is not intended to replace individual agencies’ policies and procedures.

To minimise the risk of employing an individual who poses a risk, all agencies should undertake rigorous scrutiny with respect to the candidates (including agency staff, students and volunteers) at all stages within the process.

It is a criminal offence for a barred individual to take part in Regulated Activity, or for an employer/voluntary organisation knowingly to employ a barred person in a Regulated Activity role.

Before an organisation considers asking a person to apply for a criminal record check through the Disclosure and Barring Service (DBS), they are legally responsible for ensuring that they are entitled to submit an application for the job role. See [DBS Guide to Eligibility](https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance).

For further detailed information on recruiting safely see

* [Recruiting Safely, Safer Recruitment Guidance Helping to Keep Children and Young People Safe](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2021/08/safer_recruitment_guidance_Nov09.pdf) (Children’s Workforce Development Council (2009);
* [Guidance for safer working practice for those working with children and young people in education settings](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2021/08/GSWP-Sept-2019.pdf) (Safer Recruitment Consortium (2019).

**2. Recruitment process**

Agencies should develop detailed internal procedures for recruitment to jobs and volunteer positions that involve working with children and young people, including ensuring that:

* job descriptions and person specifications reflect professional practice requirements
* previous employer references are based upon an accurate assessment of the individual’s qualities and includes any disciplinary action, known convictions or other grounds for concern
* a statement reflecting the agency’s duty to safeguard and promote the welfare of children is incorporated in any material associated with the recruitment process.

**2.1 Job description and person specification preparation**

All job descriptions and person specifications should clearly describe the role, responsibilities, accountability, knowledge, skills and experience required for the post.  They should also reflect the applicant’s responsibility to safeguard and promote the welfare of children.

The information should:

* include the statement reflecting the agency’s duty to safeguard and promote the welfare of children
* explain how the requirements will be tested/assessed during the selection process
* set out clearly the extent of the relationships and contact with children and the degree of responsibility for children that the person will have in the position to be filled
* stress that the identity of the candidate, if successful, will need to be checked thoroughly, and that where a DBS check is appropriate the person will be required to complete an application for a DBS disclosure straight away.

**2.2 Application forms**

It is good practice for organisations to use an application form to obtain a common set of data in relation to the job.

The application should include the organisation’s statement to safeguarding and include the following aspects:

* Identifying details of the applicant including current and former names, current address and National Insurance Number (ensuring compliance with the Equality Act 2010).
* A statement of any academic and/ or vocational qualifications with details of awarding body and date of award.
* A full history in chronological order since leaving secondary education, including periods of any post-secondary education/training and part-time and voluntary work as well as full time employment, with start dates, explanations for periods not in employment or education/training and reasons for leaving employment.
* Details of referees (see below; normally two should be sufficient).
* A statement of the skills and abilities, and competencies/experience that the applicant believes are relevant to his/her suitability for the post and how s/he meets the person specification.
* There should be an explanation that the post is exempt from the Rehabilitation of Offenders Act 1974.
* Information should be requested about any previous (including spent) convictions, cautions, reprimands, warnings or bind-overs.

Where gaps in employment history since leaving education are recorded these should be clarified within the candidate in the interview process.

**2.3 References**

References are an important part of the safer recruitment process and the purpose is to obtain objective and factual information to support appointment decisions.

All agencies committed to these procedures should have explicit arrangements for references which should be followed.  This should include a reference pro-forma with questions relating to the candidates suitability to work with children and focus on key criteria for effective performance in the specified post.

The application form should request both professional and character references, one of which should be from the applicant’s current or most recent employer. Where an applicant is not currently working with children, but has done so in the past, it is important that a reference is also obtained from the employer by whom the person was most recently employed in work with children in addition to the current or most recent employer.

It is recommended that references are requested prior to interview so that any issues/concerns raised by the reference can be explored with the candidate during interview.

References should be obtained directly from the referee and not rely on references/testimonials provided by the candidate, or open references/testimonials (i.e. ‘To whom it may concern’). References should not be accepted from relatives or friends.

All references must be taken up and received prior to offer of employment; this should also be the case for internal candidates.

All references should be scrutinised and any unsatisfactory gaps in employment identified from references and/or application forms should be investigated and checked.

**2.4 References with respect to agency staff**

When staff are engaged via specialist employment agencies it is important that there are systems in place to ensure that only agencies which can offer safe selection processes are used.

References should be sought as outlined above and requests to employment agencies must seek confirmation:

* that the individual was registered with the agency in the period(s) claimed
* of all assignments including dates, roles and name and address of all work places
* of any cause for concern within the agency including any request by a client for the person to be withdrawn from an assignment which upon investigation was found to be justified.

The agency must also confirm in writing:

* that it carries out appraisals of its workers and be invited to describe the most recent relevant to the role which is to be filled
* the date of the last DBS check obtained on the individual in question, who obtained it, the level of disclosure and its unique reference number
* from which previous employers references were obtained and whether or not these expressed any reservations about the individual in question
* if its overall selection procedure complies with the recommendations made in the Warner report ‘Choosing with Care’.

**2.5 Selection process**

It is essential that the same selection panel should both short list and interview candidates. Members of the panel should not stand to gain from the appointment or have a personal relationship with any of the applicants.

At least one member of the panel must have undertaken safe recruitment and selection training and one who is knowledgeable and experiences in safeguarding and child protection issues.

Each agency will have a standard procedure for short listing and interviewing to ensure that it is fair and that applicants are assessed equally against the criteria contained within the job description/person specification.

Interviews are likely to be underpinned by practical exercises. Where staff will have direct and unsupervised contact with children, the candidate’s attitude toward children and young people in general should be tested and also their commitment to safeguarding and promoting the welfare of children in particular. The following areas should be explored where possible with applicants in the interview:

* Their motivation and reasons for working with children.
* Their attitudes and behaviour about control and punishment.
* Their perceptions about the boundaries of acceptable behaviour towards children.
* Their ability to form and maintain professional relationships.
* Their understanding of safeguarding children.

Involvement of children and young people in selection processes needs to be well planned and supported in order to be effective and meaningful.

**2.6 Offering appointments to successful candidates**

An offer of appointment should be conditional upon pre-employment checks being satisfactorily completed, including:

* A DBS check appropriate to the role and to ensure an individual is not the subject of Barring.
* A check of the Teaching Agency’s list of Barred Teachers (where appropriate).
* Verification of the candidate’s medical fitness if appropriate, e.g. an intrinsic part of the role.
* Verification of any relevant professional status and whether any restrictions have been imposed by a regulatory body such as the General Teaching Council (GTC), Nursing and Midwifery Council (NMC) and the General Medical Council (GMC).
* [Evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of permission to work for those who are not nationals of a European Economic Area country.
* Receipt of two satisfactory written references, if references were not obtained prior to the interview.

It is recommended that staff should not commence work with children until the DBS check has been returned. In exceptional circumstances where the service will be at risk without the required staffing levels (e.g. schools/day care) senior managers may undertake a full risk assessment to enable staff to work until such checks have been returned. This should always include ensuring the worker does not have any unsupervised contact with children.

**3. Disclosure and Barring Checks (DBS)**

The Disclosure and Barring Service (DBS) provides two levels of disclosures which are of relevance to employers ([standard and enhanced disclosures](https://www.gov.uk/disclosure-barring-service-check/overview)), and one or other must be sought with respect to all candidates who seek to work with children.

The requirement to seek an enhanced DBS disclosure currently applies to all those who employ, or use volunteers, in types of activity called ‘Regulated Activity and other Work with Children’.

The term covers anyone working closely with children or vulnerable adults, either paid or unpaid, on a frequent, intensive or overnight basis. Frequent means once a week or more (except in health or personal care services where frequent means once a month or more); intensive means on four days or more in a single month; and overnight means between 2am and 6am (even once).

Regulated activity can include, but is not limited to:

* Teaching, training or instruction, care or supervision of children.
* Providing advice or guidance wholly or mainly for children, which relates to their physical, emotional or educational [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/).
* Any form of treatment or therapy provided to children.
* Driving a vehicle that is being used only for the purposes of conveying children and their carers.
* Working in a specified place (this may include catering, cleaning, administration and maintenance staff) in schools, pupil referral units, children’s homes, children’s hospitals, detention centres for children, children’s centres.
* Roles providing personal care.
* Registered childminding.
* Fostering and private fostering.
* Specified roles, i.e. an activity that involves people in certain defined positions of responsibility (e.g. school governor, trustees of certain charities).
* Unsupervised activities: teaching, training, instructing, caring for or supervising children, or providing advice/guidance on well-being, or driving a vehicle only for children.
* Work for a limited range of establishments (‘specified places’), with opportunity for contact: for example, schools, children’s homes, childcare premises. Not work by supervised volunteers.

Employers should make a judgement about suitability to work with children, taking into account only those offences which may be relevant to the post in question. In deciding the relevance the following should be considered:

* The nature of the appointment.
* The nature and the circumstances surrounding the offence.
* The age at which the offence took place.
* The frequency of the offence.
* Whether the individual’s circumstances have changed since the offence.

The employer should have a written policy relating to the employment of ex-offenders and the risk assessment/judgment process in the light of positive DBS disclosures, i.e. offence or intelligence disclosure.

Each agency must have a nominated ‘human resource’ or service manager whose responsibilities include reporting to the DBS and the relevant [professional body](https://www.safeguardingcambspeterborough.org.uk/glossary/professional-body/), any member of staff who (following an enquiry) it concludes to be unsuitable to work with children.

**3.1 Criminal record disclosure for overseas staff**

The same checks should be made on overseas staff as for all other staff, including DBS checks.

Where an individual has lived outside of the UK for a period of time it is important that employers take necessary steps to gather [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to prove their good conduct whilst living outside of the UK. This may include obtaining a certificate of good conduct and any other reference and/or checking the individual’s overseas criminal record via the embassy or High Commission of the country in question.

It is possible to submit a DBS application while the applicant is overseas but it is important to remember that the DBS cannot access criminal records held overseas. Therefore a criminal record check may not provide a complete picture of an individual’s criminal record.

In a small number of cases, overseas criminal records are held on the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) National Computer and these would be revealed as part of a criminal record check. However it is still necessary to verify the identity of the overseas applicant.

Further information can be found on [Home Office Guidance for employers about DBS checks for Overseas Applicants](https://www.gov.uk/guidance/dbs-check-requests-guidance-for-employers#overseas-applicants)

**3.2 Persons prohibited from working/seeking work with children**

Anyone who is barred from work with children in a regulated position, as set out in Section 36 Criminal Justice and Court Act 2000, is committing an offence if they apply for, offers to do so or accept any work in any of the regulated positions as set out in the Act and the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) must be informed without delay of the individual’s attempt to seek employment.

It is also an offence for an employer knowingly to offer work in a regulated position, or to produce work in a regulated position for an individual who is disqualified from working with children, or fail to remove such an individual from such work.

**4. Recording**

All documentation relating to the recruitment of staff must be retained on file in line with each individual employer’s records retention practices and in line with the Data Protection Act 1998. Any check completed should be confirmed in writing and retained on the candidate’s personnel file, together with photocopies of and documents used to verify his/her identity and qualifications.

Under DBS regulations, DBS disclosure certificates should not be kept for longer than necessary. This is usually for a period of up to 6 months, to allow for the consideration and resolution of any disputes or complaints. However a record should be kept of the date the disclosure was obtained and who by, the level of the disclosure and the unique reference number.  A record should be kept of [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to show that such checks have been carried out in respect of supply staff and volunteers whether recruited directly or through an agency.

Satisfactory references must be kept on the candidates personnel file or, in the case of supply staff or volunteers not recruited through an agency, on a central record within the organisation.

**5. Induction of newly appointed staff**

For all new staff working with children, including agency staff, their induction must cover safeguarding and promoting children’s welfare as outlined in local training strategies. This must include:

* an introduction to the organisation’s child protection policy and procedures
* identifying staff with designated safeguarding responsibilities
* information on safe practice
* a full explanation of their role and responsibilities
* the organisations standard of conduct and behaviour expected
* the organisation’s personnel procedures including disciplinary and whistle blowing policies.
* All new staff should attend child protection training at an appropriate level to the member of staff’s work with children.

It is good practice for organisations to have a written policy which details the nature and frequency of supervision of staff, whereby issues in relation to suitability to work with children can be promptly identified and addressed.

**6. Supervision**

Supervision enables workers to develop their capacity to use their experiences to review practice, receive feedback on their performance, build emotional resilience and think reflectively about the effectiveness of the professional relationships they have formed with children, adults and families. Regular, high quality safeguarding supervision is an essential element of effective arrangements to safeguard children.

It is recommended that supervision must:

* keep a focus on the child
* ensure that practice is consistent with the Cambridgeshire and Peterborough Safeguarding Procedures and the organisation’s own procedures
* provide a safe environment for reflection and professional challenge
* acknowledge the emotional impact of the work
* recognise and manage feelings and beliefs which may affect the safeguarding of children
* identify when a case needs to be [escalated](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/escalation_policy/) due to concerns about case progress or other aspects of case management, including ineffective multi agency working
* ensure that sufficient time is allocated for the supervision to be carried out effectively.

It is good practice that annual staff reviews are part of the organisation’s supervision policy and they should:

* ensure staff are up to date with current safe practices
* identify areas for development
* openly address any concerns about behaviour and attitudes
* put in place action plan and arrangements for review.

**Self-harm**

Self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) is any behaviour where the intent is to deliberately cause self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) without suicidal intent, resulting in non-fatal injury. This could include:

* cutting
* swallowing hazardous material or substances
* burning
* over/under-using medication, e.g. insulin
* hitting/punching/head banging
* skin picking/scratching/hair pulling
* taking an overdose of tablets
* alcohol/drug misuse
* over/under-eating
* self-strangulation / attempted hanging

Some people who self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) may have a strong desire to kill themselves. However, there are other factors motivating self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), including a desire to escape an unbearable situation or emotional pain; to reduce tension and stress; to express hostility; to take control; or to punish self or others.

Self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) has tended to be a secretive behaviour that can go on for a long time before being uncovered, although the increased incidence of self [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), especially in young women, has removed some of the taboo and it is now more likely to be talked about than it ever was previously. Children and young people may struggle to express their feelings in other ways and use the act of self [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to release their emotions.

The most common forms of self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) are cutting and overdosing, with high rates of alcohol and drug use.

**Suicidal behaviour**

Attempted suicide is self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) with the intent to take life, resulting in non-fatal injury. Suicide is self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) that results in death.

**Risks and indicators**

There are a number of risk factors that can lead to a child or young person being vulnerable to self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or suicidal behaviour, many of which are common to lots of young people but most of whom will come through them over time.  However a number of risk factors may combine leading to increased risk and, for some young people, attempted suicide or actual death by suicide may occur as a result of a crisis triggered by a ‘final straw’ stress such as a relationship breakdown, a family incident or exam pressures.

Risk factors include:

* depression or anxiety
* low self-esteem
* [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect
* unresolved issues regarding sexual orientation
* bereavement and experience of suicide by significant others
* poor parental relationships or parental separation
* hopelessness
* domestic [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)
* social isolation and loneliness
* bullying, including cyber-bullying
* academic pressure (especially related to exams in April and May)
* trauma
* suicide or self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) related internet use
* physical health conditions that may have a social impact
* trouble at school or with the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)
* alcohol or drug misuse
* family factors (mental ill health, physical illness or substance misuse)

**Warning signs**

Children or young people who are self-harming or who are contemplating suicide may display changes in behaviour, for example:

* suicide-related internet use (searching for information about suicide or posting messages with suicidal content)
* physical marks or scarring on the body
* expressions of suicidal ideation (especially to peers)
* reluctance to undress or expose specific parts of the body where injuries may be located
* changes in mood
* lowering of school grades
* becoming withdrawn
* changes in eating or sleeping habits
* expressing feelings of hopelessness or failure
* [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) of drugs or alcohol
* isolation from friends and family

Studies have also shown, however, that a proportion of young people have died as a result of suicide where this has appeared to have been ‘out of the blue’ with no known previous expression of suicidal intention, no reports of previous self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)  and where risk factors were not obviously present.  This indicates that it is not always possible to identify young people at high risk of suicide.

**Protective and Supportive action to be taken**

When an incident of self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)/suicidal behaviour is identified, the practitioner should talk to the child or young person in a respectful, calm and non-judgemental way to establish as far as possible whether they have taken any substances or injured themselves in order to establish as a priority whether the young person requires urgent medical attention.  If urgent medical attention is required then this should be arranged without delay.

If medical attention is not required then it would be appropriate to explore with the child or young person the nature of their self-harming behaviour or suicidal ideation.  This is not a formal mental health risk assessment at this stage as most practitioners will not be sufficiently qualified or experienced to undertake one, but a conversation with the young person will hopefully provide useful information which will inform a formal risk assessment by a suitably qualified practitioner (for example a GP, mental health or CAMHS practitioner) if a referral is made to a specialist service.

Questions which could be asked at this stage include:

* How long have they felt like this?
* Are they at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) from others?
* Are they worried about something?
* Do they have any health and any other problems such as relationship difficulties, [abuse](https://westmidlands.procedures.org.uk/page/glossary?term=Abuse&g=3EzN#gl51) or sexual orientation issues?
* What other risk-taking behaviour have they been involved in?
* What have they been doing that helps?
* What are they doing that stops the self-harming behaviour from getting worse?
* What could be done in school or at home to help them with this?
* How are they feeling generally at the moment?
* What needs to happen for them to feel better?
* Have they thought about ending their life?  If yes, have they thought about how they would do this?  How often do they think about doing this?  Do they have a plan now?
* Do they know anyone else who has died as a result of suicide?
* Have they told anyone else about how they are feeling and, if so, who and have they arranged support?
* Can they identify an adult they can trust to talk to should they feel the need to self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)?

**Referral to Children Social Care**

The responses provided by the young person will inform the decision about whether the child or young person is in need of additional support as part of the local early help offer, or whether an assessment by a specialist service such as CAMHS or a social work assessment is required.  Practitioners should consult their local Thresholds guidance to establish what level of intervention is required and seek advice from their designated Safeguarding Lead. If there is still uncertainty, practitioners should contact specialist services for further advice as to the appropriate intervention.

Where the risk of suicide or serious self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) is low the child or young person may require additional support which can be provided through the school or college or by an early help service commissioned to address lower level mental health issues.  Where the risks are thought to be higher it may be necessary to make a referral to CAMHS for a mental health risk assessment or, if the child is at risk of suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), a referral to children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)may be necessary.

An assessment should consider whether:

* the parents/carers are providing adequate quality of care
* the child is exhibiting behaviour beyond the control of their parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) and their self-harming behaviour is beyond parental control
* the child is too young or has learning difficulties and is unable or does not give an explanation that is consistent with self-harming
* the child is being harmed or suspected of being harmed by another adult or child – this may include injury from a sibling or bullying by other children, for example.

Each early help, [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), CAMHS or multi-disciplinary assessment must produce a plan which addresses the child’s needs, seeks to alleviate the child’s distress, and, where appropriate, seeks to support the parents/carers in their parenting of the child.

If early help services have not achieved change and/or the child is unlikely to reach or maintain a satisfactory level of health or development, or their health or development is likely to be significantly impaired, a referral to children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)  should be considered.

The referral should include information about the child/young person’s background, history and family circumstances, the community context, and the specific concerns about the current circumstances.

**Young person presenting at hospital**

Where a child or young person requires hospital treatment in relation to physical self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), practice should be as follows, in line with the National Institute of Health and Clinical Excellence (NICE) 2004 guidance (see [**NICE website**](https://www.nice.org.uk/guidance/published)):

Triage, assessment and treatment should be undertaken by paediatric nurses and doctors trained to work with children and young people who self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), ideally in a separate area of the emergency department for children and young people.

If hospital admission is appropriate all young people under 16 years  should be admitted onto a paediatric ward under the overall care of a paediatrician and assessed as soon as is practicable.  Alternative placements may be needed in some situations, depending on the child’s age, circumstances and physical/mental health.

A mental health professional should undertake a preliminary examination and decide what further assessment is required.

In cases of attempted suicide a hospital admission will usually be arranged to enable a psycho-social assessment, which should consider whether or not the child is at risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and the need to refer to CAMHS and/or children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) for assessment.   CAMHS should provide a prompt assessment once a referral has been made by a hospital on young person who has been admitted following a suicide attempt or serious incident of self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

**Information Sharing and Consent**

Children and young people need to be made aware that it may not be possible for their support workers to offer complete confidentiality. If a child or young person is at serious risk of harming themselves or others, it would not be appropriate to maintain complete confidentiality. This should be explained at the beginning of any conversation with a young person.

Information will need to be gathered from the young person about the nature and extent of their self-harming behaviour or about the nature of their suicidal thoughts of behaviours. This will inform an assessment of their needs and a plan for the provision of support or specialist services. In order to share and access information from the relevant professionals, the child or young person’s [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) will be needed. Professional judgement must be exercised to determine whether a child or young person is competent to [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) or to refuse [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to sharing information. Consideration should include the child’s age, mental and emotional maturity, intelligence, vulnerability and comprehension. A child at serious risk of self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) may lack emotional understanding and comprehension and a judgement will be required as to whether they are Gillick competent.

Advice should be sought from a child and adolescent psychiatrist if use of the Mental Health Act may be necessary to keep the young person safe.

Informed [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to share information should be sought if the child or young person is competent, unless the situation is urgent and delaying in order to seek [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) may result in serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the young person; or if seeking [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) is likely to cause serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to someone or prejudice the prevention or detection of serious crime.

If [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to information sharing is refused, or cannot/should not be sought, information should still be shared if there is reason to believe that not sharing information is likely to result in serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the young person or someone else, or is likely to prejudice the prevention or detection of serious crime; or the risk is sufficiently great to outweigh the [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or the prejudice to anyone which may be caused by the sharing.

Professionals should keep parents informed and involve them in the information sharing decision, even if a child is competent or over 16. However, if a competent child wants to limit the information given to their parents or does not want them to know it at all; the child’s wishes should be respected, unless the conditions for sharing without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) apply.

Where a child is not competent, a person with parental responsibility should give [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) unless the circumstances for sharing without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) apply.

Further clarification is available in the Government’s ‘Information Sharing and Suicide prevention Consensus Statement’ (2014).

**Further information**

* [Managing self-harm in young people](http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr192.aspx). Royal College of Psychiatrists. 2014.
* [Self-harm Quality Standard](https://www.nice.org.uk/guidance/qs34). National Institute for Health and Care Excellence. 2013.
* [Dealing with Self Harm](http://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/self-harm/). Services for Children and Young People. [NSPCC](http://westmidlands.procedures.org.uk/page/glossary?term=NSPCC&g=3gjN#gl21).
* [Truth Hurts: Report of the National Inquiry into Self-harm among Young People](http://www.mentalhealth.org.uk/publications/truth-hurts-report1/). Mental Health Foundation. 2006
* [The Truth About Self-Harm.](https://www.mentalhealth.org.uk/publication-download/truth-about-self-harm) Mental Health Foundation.
* [University of Oxford, Centre for Suicide Research](https://www.psych.ox.ac.uk/research/csr)
* [Gillick Competency](https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf)
* [Information Sharing and Suicide Prevention: Consensus Statement](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf) (2014)
* Suicide by Children and Young People: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (University of Manchester, 2017)
* [Guidance for Developing a Local Suicide Prevention Action Plan: Information for  Public Health Staff in Local Authorities (2014)](https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan)

**Useful websites**

* [keep your head](http://www.keep-your-head.com/cyp)
* [Kooth](http://www.kooth.com)
* [Self Harm](http://www.thesite.org/)
* [National Self Harm Network](http://www.nshn.co.uk/)
* [Papyrus](http://www.papyrus-uk.org/)
* [Stop Suicide](https://www.stopsuicidepledge.org/)
* [Zero Suicide Alliance](http://www.zerosuicidealliance.com/)
* [MindEd](https://www.minded.org.uk/)
* [MentalHealth.org](http://www.mentalhealth.org/)
* [Calm Harm](https://calmharm.co.uk/)
* [Young Minds](https://youngminds.org.uk/)
* [National Suicide Prevention Alliance](https://nspa.org.uk/)

**Suicide**

**Scope of this chapter**

Handling the aftermath of a suicide is particularly challenging experience for schools. The tensions between continuing to function as a school, support those who are grieving and celebrate the young person’s life, whilst not celebrating suicide is a particularly unique set of circumstances. An event such as this is very significant for young people in a school community, even if they did not know the person who has died personally.

The purpose of this guide is to support multi-agency partners to know what response processes are enacted upon the death of a young person from suicide.

This is to ensure that schools are supported in a co-ordinated approach and there is appropriate management of any escalating situations in order to reduce the likelihood of copycat suicides.

**Target Audience:**

In light of the target audience for this document is as follows:

* Social Workers in the Multi Agency Safeguarding Hub
* Child Death Overview Panel Manager
* [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)
* Practitioners and Managers who would support a school in the aftermath of a suicide
* School Heads and Pastoral Support leads (for information).

**Other Safeguarding Partnership Board Guidance:**

This guidance builds upon the current LSCB Guidance regarding young people exhibiting selfharm and suicidal behaviour, but does not replace it.

This guidance also acts as a specific annex to the multi-agency Child Death Overview Panel Procedures.

**1. The impact of a suicide on a school.**

Schools will be notified of a suicide (actual or attempted) potentially through a number of routes. The [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), the hospital, children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), or the child death overview panel are all routes by which the school may be notified of a suicide, or a serious suicide attempt.

Schools often find that the suicide of one child can have unexpected triggers throughout the school community, raising a wide variety of issues. An additional challenge is that school staff who are themselves grieving, are also offering support to pupils and parents alike. The balance between supporting young people in the aftermath of a tragedy, whilst containing escalation within the school context is a significant challenge. Young people often want to mark the occasion in a way that is very different to how adults would, particularly in their use of social media. Maintaining an appropriate compassionate response, whilst supporting students to continue with normal life and keep the school running is important. When an event like this occurs in the school holidays, schools have found that pupils may hear before the staff. Whilst that affords time for the school to put a response in place in a considered way when students return; there is a need to inform the community, when the community is not gathered together in one point and the support offered to them is less co-ordinated. It is beyond the scope of this document to consider the detail of managing a school through a suicide, but such guidance is available and signposted to below.

Schools acknowledge at this time, the need for expert advice and support from specialist service providers to empower staff to support pupils and manage the risks in regards young people’s emotional [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/). Young people could easily see the way the memory of the deceased young person is marked and consider taking a similar path to escape their own difficulties and leave a positive legacy.

The impact of a death by suicide in a school is often felt for many months after the event, with unforeseen events triggering memories and emotions in young people affected, which may again trigger the need for support. This will need to be requested by the school at the time.

All students and parents should be informed of the following online resources:

* <http://www.keep-your-head.com/cyp> this contains a wealth of information for young people, parents and professionals. There is also an adult version where the parents can access support.
* [www.Kooth.com](http://www.Kooth.com) – an online counselling and advice service for young people.

Further guidance and support for schools to consider this more can be accessed from the following:

* Cambridgeshire Education Child Protection Service: 01223 729045
* Peterborough Safeguarding Education Team 01733 207150 / 01733 452668
* Samaritans Step by Step support for Schools : https://www.samaritans.org/yourcommunity/samaritans-education/step-step
* Papyrus: Resource for Supporting Schools: https://www.papyrusuk.org/repository/documents/editorfiles/toolkitfinal.pdf

**2. Triggering a multi-agency response in the serious suicide attempt or death of a young person from suicide.**

The key to ensuring a holistic multi-agency response is early and appropriate communication with the appropriate range of professionals. Appendix 1 outlines this in diagrammatic form.

When a young person makes a serious attempt upon their own life, Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) will undertake a multi-agency discussion to consider any safeguarding issues for that young person or their sibling. The school will be invited to that multi-agency discussion. The lead agency for this meeting is Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).

When a young person makes a serious attempt on their own life, partner agencies will undertake a multi-agency discussion to consider any safeguarding issues for that young person or their sibling. The school will be invited to the multi-agency discussion. The lead agency for this meeting will be dependent on the case

When a young person dies as a result of suicide, an Information Sharing meeting, in line with the Child Death Reviews (CDR) will take place. This happens within 5 working days of the death, but likely to be sooner. The lead agency for this meeting is Health. All CDR information sharing meetings should involve the Early Help Hub to ensure consideration of the response to the school.

Key issues for both these meetings to discuss include:

* Most appropriate single point of liaison for the school (also known as the Lead CoOrdinator – see appendix 2 for a description of this role)
* Most appropriate single point of liaison for the school parents.
* Initial analysis of any risks to other members of the school community, particularly those with pre-existing mental health conditions. (see appendix 3 for proximity vulnerability guidance)
* Ensuring co-ordinated provision is offered to the school in the immediate aftermath.
* To ensure briefing of Emergency Departments if appropriate.
* Consideration of other schools when pupils/members of the friendship group have recently left
* Arranging a date for review of provision.
* Establishing a route for escalation of concerns, in order to secure further input and support.

Key people that should be part of that discussion:

* School Key contact e.g. Head Teacher or Pastoral Lead.
* Education Advisors / Education Safeguarding Manager.
* CAMH SpA Manager
* Early Help Manager (Cambridgeshire)/Early Help Services (Peterborough)
* Chums (If involved) Manager
* Emotional Health and [Wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) Manager
* [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) (if required) Manager
* Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) Manager (if case already open to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/))
* School Nursing
* Educational Psychology (If required)

It is likely that if a multi-agency discussion is held prior to a CDR information sharing meeting some of these aspects will have been put in place, however review is always beneficial. A second information sharing or multi-agency discussion may be convened, to follow up on initial actions, to ensure the response is appropriate and proportionate and to initiate any further services that may be of support to the school. In all suicides a review will occur 4 weeks after the event.

It is important that if any practitioner hears about a suicide outside of these two meetings, that we are confident the Multi Agency Safeguarding Hub (MASH 0345 045 1362) and the Child Death Reviews (CDR Capccg.cdop@nhs.net) have been informed. Both those routes then trigger the informing of the multi-agency partnership.

**3. Multi-Agency service offer to support schools and other young people.**

This section outlines the local support available both within and outside of schools in these situations. The provision of these services will be organised through either the multi-agency discussion or the information sharing meeting.

***In house School Provision:***This will vary from school to school. Often in these circumstances young people will talk to teaching assistants, teachers, and other school staff. However, as already discussed these staff are trying to maintain “normal school life” and teaching commitments, whilst handling this situation. Some schools will also have School Counsellors and Pastoral Teams who may be able to support some aspects of this situation. Schools can also signpost young people to two online services:

* www.Kooth.com – an online counselling and advice service
* http://www.keep-your-head.com/cyp – a source of information for young people, parents and professionals.

It is important to note here that every single school feels out of its depth in this situation, and needs to be supported effectively.

***Local Authority Early Help*** (Thrive Level Getting Advice, Getting Support and Getting More Help including children open to [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)):

* ***Cambridgeshire:*** (01480 376 666) The school team know their communities and in such circumstances, liaison occurs between the Early Help District Manager/ Early Help District Team and the School lead. Early Help support schools by offering a range of interventions bespoke to the school’s needs. This can include offering drop in and pre-booked sessions for students and/or parents, signpost to other services, triage students who are accessing drop-ins or showing signs of distress. This may be done in conjunction with other services for example SEND and our clinician service. If necessary, the Early Help Clinician will review the risk and vulnerability of young people as a collective to ensure that the school is managed appropriately. This will be in partnership with other staff involved and the lead co-ordinator. They will link with other professionals such as CAMH to support particular students as appropriate. This offer to schools is open ended, and led by the needs of the school. The Early Help Hub will also be alert to be prepared for referrals from that area of the county, and consider the need for post suicide support.
* ***Peterborough:*** (01733 863649) The Early Help model in Peterborough is slightly different to Cambridgeshire with the majority of services being commissioned rather than delivered in-house. However, school nursing will be available to support by contacting the school nursing helpdesk, and should the suicide be a secondary age young person, members of the Local Authority Youth in Localities Team will look to assist in providing drop-in support for students in school as part of a multi-agency package of support. A telephone conversation with any member of the Early Help Service will be able to clarify which additional services are available to support.

***CHUMS*** (Thrive Level Getting Advice and Getting Support): CHUMS are a service commissioned by Public Health and the Local Authorities. They would give schools advice and support, as well as being a place for students to be referred to for early intervention support and bereavement group work as required. For Peterborough CHUMS is the main provider of school based support services at the time of the incident, in partnership with school nursing, emotional health and [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) practitioners and youth support. http://chums.uk.com/

***School Nursing*** (Thrive Level Getting Advice and Getting Support): School Nursing are part of the initial information sharing. School Nursing do offer a direct support to siblings and assessment of risk regarding vulnerability and mental health. In Peterborough, School Nursing deliver this through school based clinics. In Cambridgeshire, as well as school based clinics, School Nurses also deliver “CHAT Health” a text based service that helps identify unmet health needs through providing young people with the opportunity to access support from school nursing. School Nurses can offer support to parents too. School Nurses can be contacted in and out of term time (area specific) through the following routes:

* Peterborough (CPFT) 01733 746822 / cpm-tr.peterboroughschoolnurses@nhs.net
* Cambridgeshire (CCS) 0300 029 5050 /ccs.cambs.hcp.schoolnursingdutydesk@nhs.net
* Young people can also access “ChatHealth” 07480635443, which offers confidential advice and support text service.

***Emotional Health and***[***Wellbeing***](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/)***Practitioners*** (Thrive Level: Getting Advice and Getting Support) (ccs.ehw@nhs.net OR 0300 555 5060 Monday – Friday 09:30 – 16:30) These practitioners go in and proactively offer support to staff in managing young people with emotional and mental health concerns. They would not see young people directly themselves. They would signpost staff, parents and students to other services across the thrive spectrum. They would also be able to support the school in the longer term.

***Child and Adolescent Mental Health Services – (CAMHS) Single Point of Access (SPA)*** (01480 428115) (Thrive level: Getting more help). Regardless of whether the young person was known to CAMHS or not, CAMHS SPA will need to be aware of the event and have a list of names of young people who are potentially vulnerable and might need a referral for CAMHS level intervention. The list is generated from the initial CDR information sharing meeting and further developed between school and the EHWB practitioners. The names on the list should meet the thresholds discussed in Appendix 3 for both Geographical and Psychological / Social factors.

The list will be kept in a confidential place for the SPA team members to access in line with our “pre-referral” processes, and will not be treated as referrals into CAMHS. The names on the list will serve to give a potential referral a context for SPA clinicians to prioritise the screening and processing of a potential referral. CAMHS will not change their thresholds for offering assessment and treatment, but will work closely with the partner agencies to share and obtain relevant information so that timely support can be offered to the young person.

SPA clinicians can be contacted to offer telephone advice and guidance to school and other professionals who are considering making a referral to CAMHS to talk through CAMHS thresholds and risks. SPA is not a crisis service.

***Crisis CAMHS.*** If a young person feels they are in crisis or if an adult caring for or working with them is concerned about their safety they can get immediate advice and support by contacting 111 and selecting option 2. This service may also be able to arrange an urgent face to face crisis assessment if that is needed. By calling 111 option 2, young people over the age of 16 can also access the sanctuary, a safe space for support in crisis, available every evening. In addition to this, hospital emergency departments are also available, especially if there is concern regarding immediate risk to the young person.

***Educational Psychologists:*** (Cambridgeshire 01223 699 859/01223 699945) (Peterborough: 01733 863689) Educational Psychologists (EPs) regularly work with schools at a systemic level and in relation to individual children and young people. Every school has a link EP and often a strong working relationship, usually with the SENDCo or equivalent. EPs are trained in trauma and bereavement and in psychological therapeutic interventions. Following a critical incident or sad event, support is offered by EPs in a consultative capacity, giving support and guidance around communicating key messages to school staff, students and the wider community, assessing needs within the school, accessing resources and supporting students and their families. In some cases where it is felt appropriate EPs might engage in some direct work with students.

[***Police***](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)***Liaison Service:*** The [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) have the responsibility for carrying out an investigation into the death on behalf of the coroner. As part of that they will look at the social media and electronic devices relating to the deceased young person. This may cause them to link with other members of the young person’s social network. At that point, in regards these young people, the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) liaison service may link directly with the school.

For national and voluntary sector support available please see http://www.keep-yourhead.com/cyp this contains a repository of information for young people, parents and professionals. www.Kooth.com also provide an online counselling and advice service for young people in Cambridgeshire and Peterborough.

**4. Ongoing assessment and escalation of risk and vulnerability within a school setting after a death by suicide.**

Supporting schools and young people in the aftermath of such an event is best enabled through a non-medical approach, this facilitates a normal response to a tragic event and supports community healing. Good partnership working with parents and specialist professionals helps to enable young people to have the emotional language required to express themselves, considering early intervention as appropriate. Parents and the family network are the first line of support for young people in this setting, however there needs to be an awareness of young people who may not be as supported as necessary by this means.

All professionals in the above services are competent at assessing risk to individual young people regarding their emotional [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) or mental health. Should a professional become concerned that there is an increasing weight of risk in a number of young children and there needs to be a further gathering of professionals to ensure a robust risk assessment and support plan is in place for the school then there needs to be another multi professional meeting. These concerns should be escalated to the lead contact for the school who is responsible for seeking appropriate senior support and calling a review meeting.

The purpose of this meeting would be

* To ensure the appropriate support is in place for children and young people exhibiting signs of distress, and identification of other known vulnerabilities from partners e.g. [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).
* To ensure avoidance of duplicating efforts and ensure clear time frame for the response.
* To ensure early identification of vulnerable peers who may also be at risk due to geographic, psychological or social proximity.
* To review effectiveness of interventions offered and ensure there is sufficient support in place for the school as a whole.
* To consider any environmental or operational changes needed at particular locations.
* To plan for longer term follow up around significant dates, or if support required again in the future.
* To identify date of next review meeting if required.
* To consider the informing of senior management and any escalation if required.

It is expected that the following professionals would be contributing to that meeting:

* School Key contact e.g. Head Teacher or Pastoral Lead.
* Education Advisors / Education Safeguarding Manager.
* CAMH SpA Manager
* Early Help Manager (Cambridgeshire)/Early Help Services (Peterborough)
* Chums (If involved) Manager
* Emotional Health and [Wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) Manager
* [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) (if required) Manager
* Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) Manager (if case already open to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/))
* School Nursing
* Educational Psychology (If required)

Of note: If levels of risk to any young person are such that there is significant or potentially significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), these young people should be referred to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/). Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) would then consider holding an appropriate multi-agency meeting and invite the relevant professionals including the school to consider the risks to these young people.

**5. The debrief and support of staff involved in caring for schools and other young people in the event of a suicide.**

There is a need to consider the welfare of all staff involved in the support of a school community in the aftermath of a death by suicide. Additionally, School staff can often be on the receiving end of blame and anger from parents. All organisations have their own occupational health processes available to staff. However, it may be appropriate to consider a debrief for all staff, or a particular staff group if required. This could be led by various individuals in the network, a discussion should take place in the network as to who is the most appropriate in each incident.

**Appendix 1: Flow chart outlining the development of a co-ordinated response:**

**Diagram

Description automatically generatedAppendix 2: The role of the Lead Co-ordinator.**

The lead co-ordinator is there to ensure oversight of the response offered by the partnership to the school. They are not accountable for the services given.

The bullet points below describe what is involved in this role:

* To be the single point of contact for the school lead into the multi-agency response
* To link with the school lead to ensure that the response is appropriate and proportionate.
* To link with the different elements of the partnership response to ensure they are aware of key issues as appropriate.
* In partnership with the school and the wider multi-agency response to escalate any concerns or call a review meeting as appropriate.

The role of Lead Co-Ordinator could be undertaken by:

* Emotional Health and [Wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) Practitioners
* Early Help Clinicians/Managers (Cambridgeshire)
* School Nursing

It is the responsibility of the Lead Co-Ordinators line manager to ensure they are sufficiently supported and debriefed.

**Appendix 3: Tool for assessing vulnerability of individuals based on proximities to suicide victim.**

Every suicide is like a stone cast into a pool of water – ripples spread out across the pool all the way to the edge, but the effects are larger closer to the point of impact. Proximity to the suicide can be considered in three regards: geographical, social or psychological. They are defined below and with aspects it could include.

* Geographical: the physical distance between a person and the incident including;
  + Did they discover the body?
  + Has there been extensive or substantial media coverage that may have impacted them.
  + Are they neighbours, family members or professionals who have attended the scene?
* Psychological and Social: The psychological and social closeness of the individual to the person who has died by suicide including;
  + Boyfriends/Girlfriends.
  + Classmates and class mates of siblings.
  + Social media connections.
  + Clubs/societies/faith group friends.
  + People contacted by the person who died on the day of death.

**Significant harm**

**The Concept of Significant Harm**

The Children Act 1989 provides the legal framework for defining the situations in which a local authority has a duty to make enquiries about what, if any, action to take to safeguard or promote a child’s welfare.

Section 47 of the Act requires that if a local authority has ‘reasonable cause to suspect that a child who lives or is found in their area is suffering or is likely to suffer Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/),  the authority shall make, or cause to be made, such enquiries as they consider necessary…’

In Section 31 Children Act 1989 as amended by the Adoption and Children Act 2002:

* ‘[Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)’ means [ill treatment](https://www.safeguardingcambspeterborough.org.uk/glossary/ill-treatment/), or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the [ill treatment](https://www.safeguardingcambspeterborough.org.uk/glossary/ill-treatment/) of another;
* ‘Development’ means physical, intellectual, emotional, social or behavioural development;
* ‘Health’ includes physical and mental health;
* ‘[Ill treatment](https://www.safeguardingcambspeterborough.org.uk/glossary/ill-treatment/)’ includes Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and forms of [ill treatment](https://www.safeguardingcambspeterborough.org.uk/glossary/ill-treatment/), which are not physical; and

Where the question of whether [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) suffered by the child is significant turns on the child’s health and development, his/her health and development must be compared with that which could reasonably be expected of a similar child.

There are no absolute criteria on which to rely to determine what constitutes Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). It is often a compilation of significant events, both acute and longstanding, which impact on the child’s physical and psychological development. Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) must consider all the circumstances when determining whether a referral about [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and / or neglect to a child satisfies the criteria for a section 47 Enquiry – for further details, please see Section 47 Enquiries Procedure.

**Categories of Abuse and Neglect**

[Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect are forms of maltreatment of a child. Somebody may cause or neglect a child by inflicting [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), or failing to act to prevent [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). Children may be abused in a family, or in an institutional or community setting; by those known to them or, more rarely by a stranger. They may be abused by an adult or adults or another child or children.

Working Together to Safeguard Children 2018 includes definitions of the four broad categories of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) which are used for the purposes of recognition:

* Physical [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* Emotional [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/);
* Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/); and
* Neglect

These categories overlap and an abused child does frequently suffer more than one type of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). This chapter provides definitions of these categories and information to help identify potential [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect and the required response.

**Physical Abuse**

Physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to a child.

It may also be caused when a parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) fabricates the symptoms of, or deliberately induces illness in a child. This unusual and potentially dangerous form of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is described as fabricated or induced illness in a child (see [Fabricated or Induced Illness Procedure](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/fabricated-or-induced-illness/)).

See also [Recognising Physical Abuse](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/recognition-of-abuse-and-neglect/#Recognising_Physical_Abuse)

**Emotional Abuse**

Emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) involves 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 causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of Emotional [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is involved in all types of maltreatment of a child, though it may occur alone.

**Sexual Abuse**

Sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/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 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](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) can take place online, and technology can be used to facilitate offline [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is not solely perpetrated by adult males. Women can also commit acts of Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), as can their children.

The Sexual Offences Act 2003 introduced a range of new sexual offences designed to address all inappropriate activity with children.

Child Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) includes:

* Rape, vaginal, anal or oral penetration committed by a male on a female or male without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) (this is the only sexual offence that can be committed exclusively by a man, as the penetration must be by a penis);
* Sexual assault by penetration: penetration of the vagina or anus with a part of the body or anything else (this is a new offence that replaces indecent assault and recognises the seriousness of penetration);
* Sexual assault: touching a person sexually without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) (this also replaces the offence of indecent assault and covers non-penetrative touching of a victim and would include fondling, masturbation, digital penetration and oral genital contact);
* Sexual activity with a child: a person 18 or over intentionally sexually touching a child under 16 (this offence replaces the offences of indecent assault and unlawful sexual intercourse – a separate offence deals with the situation where both persons involved are under 18 and reduces the penalty); these offences include situations where there is [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) between the parties; where this [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) exists, and the parties are of a similar age, it is not anticipated that any criminal proceedings will take place;
* Causing or inciting a child to engage in sexual activity: a person aged 18 or over  making a child under 16 commit a sexual act on another person (including making a child touch the offender);
* Other forms of sexual activity e.g. taking indecent photographs of children or exposing children to abusive images of children.

Child Sexual Exploitation is a form of Child Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. See also [**Child Sexual Exploitation: Definition and Guide for Practitioners (DfE 2017)**](https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners).

In law children under 16 years of age cannot [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to any sexual activity occurring, although in practice young people may be involved in sexual contact to which, as individuals, they may have agreed.  Children under 13 years cannot in law under any circumstances [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to sexual activity and specific offences, including rape, exist for child victims under this age (see Sexually Active Children Procedure).

**Neglect**

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 and development.

Neglect may occur during pregnancy as a result of maternal substance misuse. Once the child is born, neglect may involve a parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) failing to:

* Provide adequate food and clothing, shelter (including exclusion from home or abandonment);
* Protect a child from physical and emotional [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or danger;
* Ensure adequate supervision including the use of inadequate care-takers;
* Ensure access appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

Severe neglect of young children is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, long-term difficulties with social functioning, relationships and educational progress. Neglect can also result, in extreme cases, in death.

**Domestic Violence and Abuse**

These definitions are used when determining significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and children can be affected by combinations of maltreatment and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), which can be impacted on by for example domestic violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) in the household or a cluster of problems faced by the adults.

In addition, research analysing Serious Case Reviews has demonstrated a significant prevalence of [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/) in the history of families with children who are subject of Child Protection Plans. Children can be affected by seeing, hearing and living with domestic violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) as well as being caught up in any incidents directly, whether to protect someone or as a target. It should also be noted that the age group of 16 and 17 year olds have been found in recent studies to be increasingly affected by domestic violence in their peer relationships.

It should therefore be considered in responding to concerns that the Home Office definition of domestic violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) (2013) is as follows:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) between those aged 16 or over, who are or have been intimate partners or family members regardless of gender and sexuality.

This can encompass, but is not limited to, the following types of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/):

* Psychological;
* Physical;
* Sexual;
* Financial;
* Emotional.

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

**Coercive behaviour is**: an act or a pattern of acts of assault, threats, humiliation and intimidation or other [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) that is used to [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), punish, or frighten their victim.”

**Risk Indicators**

The factors described in this section are frequently found in cases of child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Their presence is not proof that [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) has occurred, but:

* Must be regarded as indicators of possible Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/);
* Must prompt the professional to seek further information;
* Justify the need for careful assessment and discussion with designated / named / lead person, manager, (or in the absence of all those individuals, an experienced colleague);
* May require consultation with and/or referral to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) – see the Making a Referral Procedure.

In an abusive relationship the child may:

* Appear frightened of the parent(s);
* Act in a way that is inappropriate to her/his age and development (though full account needs to be taken of different patterns of development and different ethnic groups).

The parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) may:

* Persistently avoid child health services and treatment of the child’s illnesses;
* Have unrealistic expectations of the child;
* Frequently complain about / to the child and fail to provide attention or praise (a high criticism / low warmth environment);
* Be absent;
* Be misusing substances;
* Persistently refuse to allow access on home visits;
* Be involved in domestic violence;
* Be socially isolated.

Consideration must be given to the impact on the care of the child of any issues / problems affecting the parents e.g. substance misuse, mental health problems, learning disabilities, childhood experiences of severe neglect.

Staff should be aware of the potential risk to children when individuals, previously known or suspected to have abused children, move into or have substantial access in the household (see [Managing Individuals Who Pose a Risk of Harm to Children](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/individuals-who-pose-risk-of-harm/)).

It should be recognised that those who pose a risk to children often will not be honest with others. Staff should be mindful of this. Of particular note are carers who present a risk due to either fabricating or inducing illnesses within the children they are responsible for – see [Fabricated or Induced Illness Procedure](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/fabricated-or-induced-illness/).

Practitioners should, in particular, be alert to the potential need for early help for a child who:

* is disabled and has specific additional needs
* has special educational needs (whether or not they have a statutory Education, Health and Care Plan)
* is a young [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)
* is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
* is frequently missing/goes missing from care or from home
* is at risk of modern slavery, trafficking or exploitation
* is at risk of being radicalised or exploited
* is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/)
* is misusing drugs or alcohol themselves
* has returned home to their family from care
* is a privately fostered child

**Recognising Physical Abuse**

This section provides information about the sites and characteristics of physical injuries that may be observed in abused children. It is intended primarily to assist staff in the recognition of bruises, burns and bites which should be referred to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and / or require medical assessment.

Further useful information can be found on the Core Info website, about a series of systematic reviews defining the [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) base for the recognition and investigation of physical child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and neglect.

The following are often regarded as indicators of concern:

* An explanation which is inconsistent with an injury;
* Several different explanations provided for an injury;
* Unexplained delay in seeking treatment;
* Parents / carers who are uninterested or undisturbed by an accident or injury;
* Parents who are absent without good reason when their child is presented for treatment;
* Repeated presentation of minor injuries (which may represent a ‘cry for help’ and if ignored could lead to a more serious injury) or may represent fabricated or induced illness (see [Fabricated or Induced Illness Procedure](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/fabricated-or-induced-illness/));
* Family use of different doctors and A&E departments;
* Reluctance to give information or mention previous injuries.

**Acute Life Threatening Event**

Most acute life threatening events have a medical or physiological basis, although a precise explanation is not always found. Some have unnatural causes and assessment should always include consideration of these through careful history taking, examination and investigation similar to the list for unexplained deaths.

Child protection checks must be initiated for the child and any siblings. Any suspicions must be reported immediately to the duty social worker.

**Bruising**

Children can have accidental bruising, but the following must be considered as highly suspicious of a non-accidental injury unless there is an adequate explanation provided and experienced medical opinion sought:

* Any bruising or other soft tissue injury to a pre-crawling or pre-walking infant or non-mobile disabled child;
* Bruising in or around the mouth, particularly in small babies which may indicate force feeding;
* 2 simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive);
* Repeated or multiple bruising on the head, or on sites unlikely to be injured accidentally;
* The outline of an object used e.g. belt marks, hand prints or a hair brush (a pinch causes small double bruises, a punch or kick causes an irregular bruise with a paler centre, gripping causes ovals from fingertips or lines between fingers);
* Linear pink marks, haemorrhages or pale scars may be caused by ligature, especially at wrists, ankles, neck, male genitalia;
* Bruising or tears around, or behind, the earlobe(s) indicating injury by pulling or twisting;
* Bruising around the face;
* Broken teeth and mouth injuries (a torn frenulum – the flap of tissue in the midline under the upper lip – is highly suspicious);
* Grasp marks on small children;
* Bruising on the arms, buttocks and thighs may be an indicator of Sexual [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

Bruises are difficult to age accurately because they change colour at differing rates.

**Bite Marks**

* Bite marks can leave clear impressions of the teeth. Human bite marks are oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.te treatment or adequate explanation.

A medical opinion from a forensic dentist / odontologist should be sought where there is any doubt over the origin of the bite.

**Burns and Scalds**

It can be difficult to distinguish between accidental and non- accidental burns and scalds, and will always require experienced medical opinion. Any burn with a clear outline may be suspicious e.g:

* Circular burns from cigarettes are characteristically punched out lesions 0.6 – 0.7 cm in diameter, and healing, usually leaves a scar;
* Friction burns resulting from being dragged;
* Linear burns from hot metal rods or electrical fire elements;
* Burns of uniform depth over a large area;
* Scalds that have a line indicating immersion or poured liquid (a child getting into hot water of her/his own accord will struggle to get out and cause splash marks);
* Old scars indicating previous burns / scalds which did not have appropriate treatment or adequate explanation.

Scalds to the buttocks of a small child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.

**Fractures**

Fractures may cause pain, swelling and discolouration over a bone or joint.

Non-mobile children rarely sustain fractures.

There are grounds for concern if:

* The history provided is vague, non-existent or inconsistent with the fracture type;
* There are multiple fractures or old fractures (in the absence of major trauma, birth injury or underlying bone disease);
* Medical attention is sought after a period of delay when a fracture has caused symptoms e.g. swelling, pain or loss of movement;
* There is an unexplained fracture in the first year of life.

**Scars**

A large number of scars or scars of different sizes or ages, or on different parts of the body, may suggest [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

**Shaken Baby Syndrome**

Shaking and/or inflicting an impact injury on a baby often results in no visible external injury. Nevertheless, significant internal injuries may be caused, e.g. intra-cranial bleeding, brain injury, small fractures to the ends of the long bones, other fractures (such as ribs and neck) and retinal haemorrhages. Signs and symptoms can be non-specific, which may result in a delay in seeking advice.

The infant can present with:

* Lethargy;
* Poor feeding;
* Vomiting;
* Stops in breathing (apnoea);
* Pallor;
* Variable consciousness;
* Irritability;

In suspected cases it is essential that a full paediatric assessment is carried out including an ophthalmological examination, blood tests and CT/MRI scans/skeletal survey (according to the RCR/RCPCH guidance).

**Self-Harming and Siblings**

Caution must be used when interpreting an explanation by parents/carers that an injury or series of injuries was self-inflicted or caused by a sibling. This is especially important in young or disabled children not able to offer a reliable explanation themselves.

Due consideration must be given to the possibility that the injury may:

* Be non-accidental, particularly if the explanation appears discrepant for the nature of the injury;
* Possibly have occurred in circumstances where neglect is a consideration.

In these circumstances a referral to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) should be made in accordance with the Making a Referral Procedure

**Recognising Emotional Abuse**

Emotional [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) may be difficult to recognise, as the signs are usually behavioural rather than physical.

Indicators of Emotional [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) are also often associated with other forms of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

Recognition of Emotional [Abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is usually based on observations over time and the following offer some associated indicators:

**Parent /**[**Carer**](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)**and Child Relationship Factors**

* Abnormal attachment between a child and parent / [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) e.g. anxious, indiscriminate or failure to attach;
* Persistent negative comments about the child or ‘scape-goating’ within the family;
* Inappropriate or inconsistent expectations of the child e.g. over-protection or limited exploration.

**Child Presentation Concerns**

* Delay in achieving developmental, cognitive and / or other educational milestones;
* Failure to thrive / faltering growth;
* Behavioural problems e.g. aggression, attention seeking;
* Frozen watchfulness, particularly in preschool children;
* Low self-esteem, lack of confidence, fearful, distressed, anxious;
* Poor relationships with peers, including withdrawn or isolated behaviour.

**Parent /**[**Carer**](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/)**Related Issues**

* Dysfunctional family relationships including domestic violence;
* Parental problems that may lead to lack of awareness of child’s needs e.g. mental illness, substance misuse, learning difficulties;
* Parent or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) emotionally or psychologically distant from the child;
* Contextual factors may include:
* Child left unsupervised / unattended;
* Child left with multiple carers;
* Child regularly late attending, or, not being collected from school;
* Child repeatedly reported lost / missing;
* Parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) regularly unaware of child’s whereabouts;
* Child regularly not available for meetings with childcare workers.

**Recognising Sexual Abuse**

Please also see: [Policy Document for the referral of Child and Young Persons to the Sexual Assault Referral Centre](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/policy-document-for-the-referral-of-child-and-young-persons-to-the-sexual-assault-referral-centre/).

Children of all ages and gender may be sexually abused and are frequently scared to say anything due to guilt and/or fear. This is particularly difficult for a child to talk about and full account should be taken of the cultural sensitivities of any individual child / family.

Recognition can be difficult, unless the child discloses and is believed. There may be no physical signs and indications are likely to be emotional / behavioural.

**Behavioural Indicators**

* Inappropriate sexualised conduct;
* Sexually explicit behaviour, play or conversation, inappropriate to the child’s age;
* Continual and inappropriate or excessive masturbation;
* Self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) (including eating disorder), self-mutilation and suicide attempts;
* Involvement in prostitution or indiscriminate choice of sexual partners;
* An anxious unwillingness to remove clothes for – e.g. sports events (but this may be related to cultural norms or physical difficulties);
* Running away.

**Physical Indicators**

* Pain or itching of genital area;
* Vaginal discharge;
* Sexually transmitted infections;
* Blood on underclothes;
* Pregnancy;
* Physical symptoms e.g. injuries to genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted infection, presence of semen on vagina, anus, external genitalia or clothing.

**Recognising Neglect**

[Evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of neglect is built up over a period of time and can cover different aspects of parenting.

**Child Related Indicators**

* An unkempt, inadequately clothed, dirty or smelly child;
* A child who is perceived to be frequently hungry;
* A child who is observed to be listless, apathetic and unresponsive with no apparent medical cause; displaying anxious attachment; aggression or indiscriminate friendliness;
* Failure of a child to grow or develop within normal expected patterns with an accompanying weight loss or speech / language delay;
* Recurrent / untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice / scabies;
* Unmanaged / untreated health / medical conditions including poor dental health;
* Frequent accidents or injuries;
* A child frequently absent from or late at school;
* Poor self esteem;
* A child who thrives away from the home environment.

**Indicators in the Care Provided**

* Failure by parents or carers to meet basic essential needs e.g. adequate food, clothes, warmth, hygiene, sleep;
* Failure by parents or carers to meet the child’s health and medical needs e.g. poor dental health, failure to attend or keep appointments with health visitor, GP or hospital, lack of GP registration, failure to seek or comply with appropriate medical treatment;
* A dangerous or hazardous home environment including failure to use home safety equipment, risk from animals;
* Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating;
* A lack of opportunities for child to play and learn;
* Child left with adults who are intoxicated or violent;
* Child abandoned or left alone for excessive periods;
* Neglect of pets.

Where there are any concerns about the neglect of a child in a household, consideration must be given to the possibility that other children in the household may also be at risk of neglect or [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

**Obesity**

Obesity in children is an increasingly common problem in the general population and differentiating when there is a Safeguarding issue can be difficult and complex. Neglect can result in poor supervision of food intake, or an inappropriate diet being offered to the child with resultant excessive weight gain. A sedentary lifestyle with limited opportunity for physical activity, when combined with an inappropriate diet, can result in excessive weight gain.

It is important to take into account:

1. The impact of the obesity on the child, particularly [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) that the child is developing medical complications (e.g. undue breathlessness), restrictions in day to day activities or social/emotional difficulties as a result of their obesity;
2. The context / is there other [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of emotional [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or neglect.

Excessive calorie intake is the cause of most childhood obesity. In a very small proportion of obese children there is an underlying medical cause. The parent/[carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) is responsible for monitoring their child’s diet and seeking appropriate advice/support if the child or adolescent is overweight or obese. The management of obesity in children therefore requires parental engagement to enable and support their child to adopt healthy eating patterns, participate in age appropriate levels of physical activity and attend medical and dietetic appointments as necessary. Parental failure to engage with an appropriate management plan in a child who is severely obese and/or is developing serious complications of obesity should be considered a safeguarding issue.

**Impact of Abuse and Neglect**

The sustained [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) or neglect of children physically, emotionally, or sexually can have long-term effects on the child’s health, development and well-being. It can impact significantly on a child’s self-esteem, self-image and on their perception of self and of others. The effects can also extend into adult life and lead to difficulties in forming and sustaining positive and close relationships. In some situations it can affect parenting ability and lead to the perpetration of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) on others.

In particular, physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) can lead directly to neurological damage, as well as physical injuries, disability or at the extreme, death. [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) may be caused to children, both by the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) itself, and by the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) taking place in a wider family or institutional context of conflict and aggression. Physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties.

Severe neglect of young children is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long term difficulties with social functioning, relationship and educational progress. Neglect can also result in extreme cases in death.

Sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) can lead to disturbed behaviour including self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), inappropriate sexualised behaviour and adverse effects which may last into adulthood. The severity of impact is believed to increase the longer the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) continues, the more extensive the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and the older the child. A number of features of sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) have also been linked with the severity of impact, including 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](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), once recognised or disclosed, is strengthened by the support of a non-abusive adult or [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) who believes the child, helps the child to understand the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and is able to offer help and protection.

There is increasing [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of the adverse long-term consequences for children’s development where they have been subject to sustained emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). Emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/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](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) may be as important, if not more so, than other more visible forms of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) in terms of its impact on the child. [Domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/), adult mental health problems and parental substance misuse may be features in families where children are exposed to such [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

The context in which the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) takes place may also be significant. The interaction between a number of different factors can serve to minimise or increase the likelihood or level of Significant [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/). Relevant factors will include the individual child’s coping and adapting strategies, support from family or social network, the impact and quality of professional interventions and subsequent life events.

**Non-recent (Historical) Abuse**

**Non-recent**[**abuse**](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) (also known as historical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)) is an allegation of neglect, physical, sexual or emotional [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) made by or on behalf of someone who is now 18 years or over, relating to an incident which took place when the alleged victim was under 18 years old.

Allegations of child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) are sometimes made by adults and children many years after the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) has occurred. There are many reasons for an allegation not being made at the time including fear of reprisals, the degree of control exercised by the abuser, shame or fear that the allegation may not be believed. The person becoming aware that the abuser is being investigated for a similar matter or their suspicions that the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is continuing against other children may trigger the allegation.

Reports of historical allegations may be complex as the alleged victims may no longer be living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. Such cases should be responded to in the same way as any other concerns and the [**Referrals Procedures**](http://cambridgeshirescb.proceduresonline.com/chapters/contents.html#refer) should be followed. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for, children.

**N.B.** Historical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is not just about professionals. Also refers to past familial (etc) [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/).

Organisational responses to allegations by an adult of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) experienced as a child must be of as high a standard as a response to current [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) because:

* There is a significant likelihood that a person who abused a child/ren in the past will have continued and may still be doing so;
* Criminal prosecutions can still take place despite the fact that the allegations are historical in nature and may have taken place many years ago.

If it comes to light that the historical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) is part of a wider setting of institutional or organised [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/), the case will be dealt with according to the [**Organised and Complex Abuse Procedure**](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/organised-and-complex-abuse/).

**The lived experience of the child**

The ‘lived experience of the child is; ‘What a child sees, hears, thinks and experiences on a daily basis that impacts on their personal development and welfare whether that be physically or emotionally. As practitioners we need to; actively hear what the child has to say or communicate, observe what they do in different contexts, hear what family members, significant adults/carers and professionals have said about the child, and to think about history and context. Ultimately we need to put ourselves in that child’s shoes and think ‘what is life like for this child right now?’ [**Definition of ‘lived experience’ task and finish group 2018**]

**Background and Research**

**A Child Centred Approach**

According to the UK Government’s ratification of the United Nations Convention on the Rights of the Child (CRC) in 1991 recognised children’s rights to expression and to receiving information. In relation to all children’s right to express and have their views given due weight, Article 12 of the Convention grants that:

‘(1) States parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with age and maturity of the child.’

This right is reinforced by Article 10 of the Human Rights Act 1998 and the Children Act 1989, which requires a local authority to ascertain the ‘wishes and feelings’ of children and give due consideration (with regard to the child’s age and understanding) to these when determining what services to provide, or what action to take.

Professor Eileen Munro stated that ‘everyone involved in child protection should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation in decisions about them in line with their age and maturity’. In other words ‘the system [child protection] should be child-centred’ [2011:26]

**Working Together to Safeguard Children and Young People**

Working Together 2018 states that; ‘Children are clear about what they want from an effective safeguarding system. These asks from children ***should guide***the behaviour of practitioners.

**Children have said that they need ….**

* **vigilance**: to have adults notice when things are troubling them
* **understanding and action**: to understand what is happening; to be heard and understood; and to have that understanding acted upon
* **stability**: to be able to develop an ongoing stable relationship of trust with those helping them
* **respect**: to be treated with the expectation that they are competent rather than not
* **information and engagement**: to be informed about and involved in procedures, decisions, concerns and plans
* **explanation**: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
* **support**: to be provided with support in their own right as well as a member of their family
* [**advocacy**](https://www.safeguardingcambspeterborough.org.uk/glossary/advocacy/): to be provided with [advocacy](https://www.safeguardingcambspeterborough.org.uk/glossary/advocacy/) to assist them in putting forward their views
* **protection**: to be protected against all forms of [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) and discrimination and the right to special protection and help if a refugee

Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them and their families collaboratively when deciding how to support their needs. Special provision should be put in place to support dialogue with children who have communication difficulties, unaccompanied children, refugees and those children who are victims of modern slavery and/or trafficking….In addition to practitioners shaping support around the needs of individual children, local organisations and agencies should have a clear understanding of the collective needs of children locally when commissioning effective services’ [2018: 11- 13]

**What do National Serious Case Reviews and Research tell us?**

**Key findings**

**Babies** (under one) and **teenagers** feature the most within Serious Case Reviews. Arguably, this could be because babies cannot tell us what’s going on and as practitioners we fail to make observations as to how they interact with their parents/ carers/ family and surroundings; whilst teenagers we reportedly find ‘hard to reach’ or difficult to engage. Often children and young people misbehaving or acting out is recorded as a ‘difficult’ or ‘demanding child’ (Brandon et al 2016) and not that their behaviour is, either; a way of trying to communicate with us or a result of something which has happened to them.

**Ofsted** reported in 2011 that; there are ‘five main messages with regard to the voice of the child. In too many cases:

* the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
* agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute
* parents and carers prevented professionals from seeing and listening to the child
* practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child
* agencies did not interpret their findings well enough to protect the child’

Ofsted also found that where SCR featured babies and young children, agencies failed to observe and record their observations of parents interacting with the child (and vice versa) and that practitioners often forgot the other children (siblings) within the family. [2011:9 -10]

Marion Brandon et al’s (2016), recent work on ‘Pathways to [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), pathways to Protection from their triennial analysis of serious case reviews over a three year period (2011 – 2014) found similar findings that professionals either failed to see or to communicate with the child.

Our local Serious Case Reviews and Multi-Agency Reviews show the same findings as national SCRs, in that as practitioners across all agencies; we failed to;

* speak to the child
* engage with children and young people
* involve children and young people in planning and reviews regarding their lives or
* to observe the wider picture of what a child’s home life/ relationship with parents is

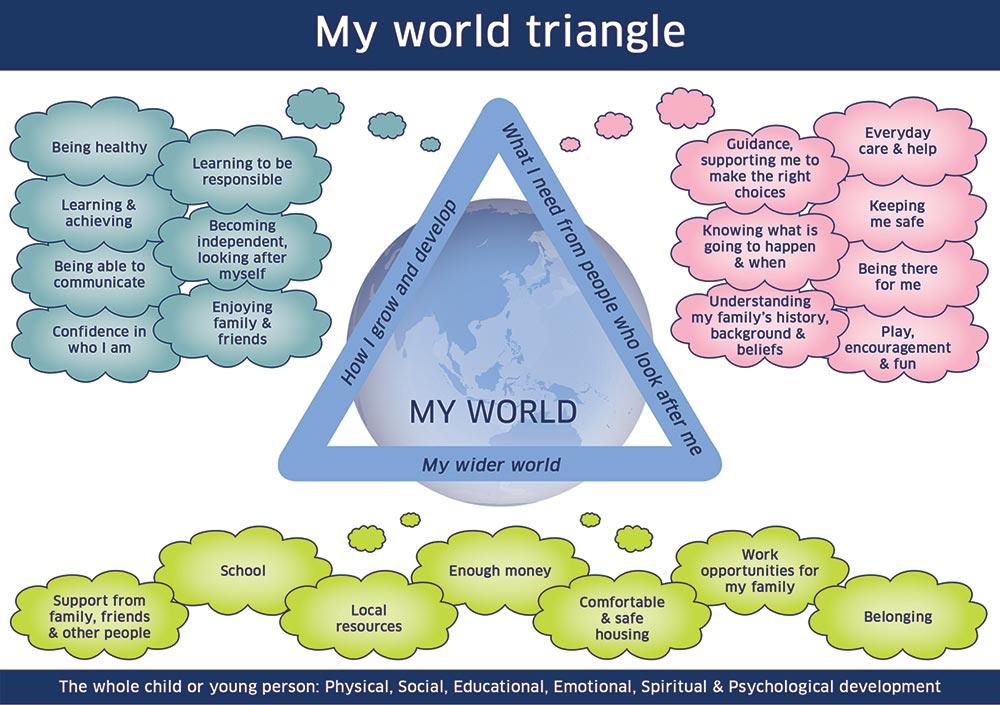
**Practice Guidance**

**Child and Adolescent Development**

It is important that the child’s responses are observed, in the context of, and with a full understanding of key child and adolescent developmental and behavioural stages. Practitioners need to know and understand what ‘normal’ child and adolescent development is in order to; ascertain if the child is thriving and developing normally and to adjust practice accordingly at a level which the child will understand.

Conversely practitioners should also be aware of what is ‘not’ normal child and adolescent development/behaviours. Practitioners need to be aware that some behaviours could be a way that the child is trying to communication or may be a result of child [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/). For example a child uncharacteristically misbehaving and acting out towards family and friends might not be the child being difficult or just ‘being a teenager’ but could be a result of the child suffering extreme pain (findings from Cambridgeshire SILP 2013). The practitioner has to set this behaviour in the context of what is ‘normal for that individual child’ and to ask them/observe why their behaviour has changed.

A child’s developmental needs, parenting capacity and family and environmental factors are dimensions within the assessment framework triangle which professionals utilise to help to ‘assess’ a child’s experiences and current home situation. The ‘My World’ triangle builds on the assessment framework in a format which can be used directly with children and young people.



According to Scotland’s Government website (where triangle and additional prompts can be found), the triangle can be used to ‘gather more information from other sources (some of it possibly specialist), to identify the strengths or [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) concerns in the child or young person’s world’ and that it**‘**supports practice that considers the child or young person’s needs and risks, as well as the positive features in their lives’

**Cultural Competence as part of the child’s lived experience**

[Cultural competence](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/) is being respectful of and responsive to the beliefs, practices and cultural and linguistic needs of diverse communities both from the individual (practitioner) and the organisation (agency). When referring to ‘communities’ this extends to areas such as; socio-economic back ground, race, gender, mental health, sexual identity/ orientation, religion, disability etc. In other words professionals ***should not make assumptions*** about a family/child and as part of ‘informed practice’ should be confident to ask about what their life experiences are in order to meet their needs and to provide the best service.

National and Local serious case reviews have shown us that as professionals we can make the wrong stereotypical assumptions and not check out all available avenues of information. Daniel Pelka was believed to not speak English, as this was recorded as his ‘second language’, even though his older sister could speak English and would translate Daniel’s interactions to staff. In Daniel’s case the reason for him not speaking English could have been attributed to developmental delay or from the [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) he was suffering from his mother and her partner.

**Research findings and cultural competence**

Children can be abused **regardless** of their age, gender, culture, disability, racial origin, sexual identity or social class. Research tells us that; disabled children are significantly more likely to be abused than non-disabled children, given that they; are more reliant on families and institutions for support, may have difficulties in communication, are more vulnerable and are more likely to be bullied by peers.

Cases and assessments often [recent SCPB audit activity] refer to missing/absent fathers or sometimes do not mention any father figures at all. Professionals should check out with families/young people if there are any significant males in the child’s life and where they are. Practitioners should take into consideration where and when would be best to complete assessments and interviews so that dads can be present and a part of the child’s wider experience of life.

**Finding out about the lived experience of the child**

Practitioners need to be confident and competent when working to safeguarding children and families. Research, locally and nationally, provides areas of practice which support finding out about ‘the lived experience of the child.’ Some are the more salient ones listed here include, for professionals to have:

[**Professional Curiosity**](https://www.safeguardingcambspeterborough.org.uk/glossary/professional-curiosity/)**:** practitioners need to understand what is happening within a family rather than making assumptions or accepting things at face value. In other words they need to ***ask questions*** and observe the child’s surroundings. Ask them ‘What is life like for the child living at home?’ ‘What is it like for the family?’ ‘How does the child react to parents?’

[**Respectful Uncertainty**](https://www.safeguardingcambspeterborough.org.uk/glossary/respectful-uncertainty/): A term initially used by Lord Lamming (2003) [Victoria Climbie Serious Case Review and again for Baby P] meaning that professionals must remain sceptical of the explanations, justifications or excuses they may hear. Professionals should always ‘***check out’*** with other agencies and sources of information about what is being said.

Eileen Munro (2011), whilst referring to Ofsted’s findings [2011:8] gave a number of helpful suggestions for practitioners to follow when making assessments on children and young people. For practitioners to:-

* use direct observation of babies and young children by a range of people and make sense of these observations in relation to risk factors
* see children and young people in places that meet their needs – for example, in places that are familiar to them
* see children and young people away from their carers
* ensure that the assessment of the needs of disabled children identifies and includes needs relating to protection and Don’t forget father figures within the family and about the wider family / friends – what can they tell us about the child?
* Actively listen to a child and pay attention to their needs and do not focus too much on the parents, especially when the parents are vulnerable themselves. (it is easy to get lost with parental needs at the risk of losing sight of the child)

Marion Brandon et al (2016) added further elements, that professionals need to:

* Be aware of ‘silent’ ways of telling through verbal and non-verbal emotional and behavioural changes in children
* Explore creative ways of engaging with children with regards to their age, communication skills and personal history to enable them to share their experiences
* Follow up concerns within families by ensuring each child is given an appropriate opportunity to talk
* Professionals need to recognise young people aged 16-17 years as still being vulnerable and to use appropriate children’s services and follow safeguarding procedures [2016:Ch6:134]

Both Brandon and Munro advocate that as professionals we need to be ‘attuned to the child’s world’ and to pay attention not only to what the child says but also what they are ***not*** ***saying***.

**Local Experiences and Lessons Learned for Future Practice**

Case studies listed below give an overall view, in relation to the lived experience of the child, as to what could have been done differently to ‘hear the voice of the child’ for safeguarding that child / young person.[/vc\_column\_text]

**Case Study – Alesha**

Alesha is four years old and lives with her mother, step-father and older brother and is not known to have had any previous involvement with services. Her mother states that English is her second language and says that she ’can’t speak English’ – this is recorded on her medical files. Her mother has taken her to the general practitioner (GP) on a few occasions with suspected urinary infections. On one occasion, when in hospital being treated for a possible adverse reaction to the water infection medication, hospital staff checked to see if Alesha was ‘known to children [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)’ but did not report any child protection/safeguarding concerns. Several weeks later her mother took her to the GP with severe trauma to her genital area. The doctor asked her parents to take Alesha to the hospital (emergency department) and gave them a letter to take with them. Eight hours later Alesha was taken to the hospital by her parents and a child protection referral was immediately made by the hospital staff. Alesha was treated and admitted onto a ward within the hospital and this was deemed as a ‘place of safety’ whilst the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) made their enquiries.

Alesha had to undergo a number of medical procedures and one ward staff member reportedly ‘felt sorry’ for her being so young and having to experience invasive procedures. The staff member started to try to have a conversation with Alesha, even though it was recorded on files that she could not speak English. Alesha responded to the staff member and could communicate with her and speak English.

**Missed Opportunities to hear the lived experience of the child**;

In this case staff members ([police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) and health) were not ***‘professionally curious’*** at many of the stages of contact with Alesha and could have tried to speak/communicate with her and to find out ‘what life was like for her’ and to maybe ask why she had the symptoms that her mother had taken her to the GP and hospital with.

Additionally professionals did not display ***‘***[***respectful uncertainty***](https://www.safeguardingcambspeterborough.org.uk/glossary/respectful-uncertainty/)***’*** and check out with Alesha and other family members what the mother had told them about her not being able to speak English. In terms of [***cultural competence***](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/) staff made incorrect ‘assumptions’ that Alesha would not be able to communicate with them.

There was an older brother in this case and professionals did not ***‘think sibling’*** .He was not taken into protective care/place of safety until several days later and no one had spoken to him about; his life experiences (was he at risk of sexual [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)?), what he thought about his sister nor what might have happened to him/her.

**Case Study – Sonia**

Sonia was a 13 year old girl, from central Europe, living within the Fenland area with her mother and step-father. She became actively involved with a ‘negative’ peer group who placed her at ‘serious risk’ of child sexual exploitation (CSE). Sonia soon became withdrawn and started to miss lessons and was absent from school (on a number of occasions) and was said to be showing signs of isolation from the Fenland community due to language barriers. There were reports, from her mother that whilst Sonia was missing she had been drinking alcohol and sleeping naked in an older boy’s bed.

As a result of Sonia’s difficult behaviour at home her mother said that; she used physical chastisement (using a belt) to try to set boundaries and to discipline her. Sonia reported this at school and children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) were involved due to the physical [abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/) from parents and that Sonia did not want to return home. After five days in foster care Sonia was returned home, against her wishes, as her mother wanted her home. In 2016 Sonia was made the subject of a child protection plan.

In June 2016 it was recorded, on [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) files that; Sonia had been plied with drugs and alcohol, by a 27 year old male and then he sexually assaulted her. On health files it was noted that Sonia had tried to self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) at home and had been physically assaulted by her parents when she told them about the sexual assault; that she had been given crystal meth by an older man and then raped.

**Missed Opportunities to hear the lived experience of the child:**

Agencies ([social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/), health and education) should have been *‘****professionally curious’*** when working with Sonia throughout this case:-

* Why was she ‘withdrawn’ at school and ‘missing’ lessons?
* Could Sonia have said more about her peer group, who they were, what they did – was this normal adolescent behaviour or something else for Sonia?
* What was life like for Sonia? – at home /at school / with friends?
* When Sonia was asked about her home life, she said it was ‘normal’ workers interpreted this as being ‘fine’ – what did ‘normal’ really mean for Sonia?
* Sonia could have been ***asked*** or ***consulted*** regarding agency actions which may have informed professionals about how she felt and supported the identification of any further risks to her.

Agencies should have offered ‘[**respectful uncertainty**](https://www.safeguardingcambspeterborough.org.uk/glossary/respectful-uncertainty/)**’** when working with parents to check out what they were telling them in relation to Sonia and their perceived experiences with her

In terms of [***cultural competence***](https://www.safeguardingcambspeterborough.org.uk/glossary/cultural-competence/)professionals made a number of assumptions and did not consider the individual needs of Sonia or her parents:

* How might a family react to certain circumstances? Think about what’s life like for the family in question – what might a sexual assault on their child mean for them? How might they react? Will the child be at risk after they have been informed?
* When families go away for holidays to their country of origin, do not make the assumption that they have left the country and will not be returning and then close the case.
* Does the family and child need the support of an interpreter / is this recorded on file?

Cases adapted and taken from a Cambridgeshire Significant Incident Learning Process 2014 and Cambridgeshire and Peterborough Multi-Agency Review 2018

**How do Professionals ascertain the Lived Experience of the child?**

During early 2020 a professionals’ survey undertaken by the partnership board asked how practitioners and managers put the child at the centre of their practice within assessments and planning. There were many responses and some of the more salient comments that can be used within general safeguarding practice from both practitioners and mangers perspectives are listed below;

As a Practitioner, I will……….

* When I record information during a meeting or telephone call I will check with them that I have captured all the details they wanted me to
* Complete activity sheets with children to capture what their week looks like and their wishes and feelings
* Ensure that their views are shared on their behalf and act on them as much as possible ensuring that they are benefiting that individual and not putting them at risk
* Work in a Child Centred Approach
* Use observations from my visits with pre-verbal children
* Invite children and young people into meetings if appropriate, use motivational interview assessment tools – decision balance tools, scaling and active listening
* Ensure that… my work is done ‘with’ families and children, not ‘to’
* Empower and support young people in making decisions and being more in control of their lives
* Use tools that support the children’s and families’ voice and use these to inform plans and assessments

Practitioners comments taken and adapted from the Partnership Board’s Professionals Survey 2020

As a Manager, I will …..

* Work in a Child Centred Approach
* Use supervision as a space to explore ways in which to work openly with children and families including using various tools and techniques for discussing wishes and feelings of children
* Consistently reinforce the importance of safeguarding and promoting the welfare of children to my staff at every opportunity
* Oversee the final care and safety plans that my team produce and ensure that it’s clear that children and young people have participated
* Have management oversight of the service users supervised by my organisation
* Through audits and dip sampling ensure that family plans and case notes all record voice of the child/young person/adult and these are linked throughout plans and intervention
* Ensure the design and delivery of safeguarding training is structured with ‘what life’s like for the child’ case studies alongside academic / information / content
* Consider what it is like for the child in those particular circumstances at that time in that family. EG do they feel safe? Do they feel loved? Are they frightened? Are they hungry or cold?

Managers comments taken and adapted from the Partnership Board’s Professionals Survey 2020

**References**

Brandon, M et al (2014)(2011)(2010)(2009)(2008)

HM Government (2018) *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: Department for Education

Laming, H. (2003) *The Victoria Climbié Inquiry*. London: HMSO

Munro, E. (2011b). *The Munro review of child protection: Final report – a child-centred system*. London: Department for Education.

Ofsted (April 2011):*The voice of the child :Learning lessons from SCR:A thematic evaluation of SCR from 1 April  to 30 September 2010*

Sidebotham.P;Brandon.M;Bailey.S;Belderson.P;Dodsworth.J;Garstang.J;Harrison.E;Retzer.A;Sorensen.P;(2016); *Pathways to*[*harm*](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)*, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014*. University of Warwick University of East Anglia. Department for Education

(Daniel Pelka: 2013) <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews>

Cambridgeshire and Peterborough Serious Case Reviews <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/>

**Partner Resources**

This section of the guidance gives a list of some of the tools which are utilised within single agencies for working directly with children and young people. It is not meant to be an exhaustive list of all of the tools available in every agency, but serves as a point to start from, in terms of; awareness and who to contact to find out more.

**Children Social Care / Early Help**

**Mind of My Own** – utilised within Children [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) (Pboro and Cambs) is an electronic way (by phone / app/ laptop) of gaining children / young people’s thoughts ‘makes it easier for children and young people to express their views’

Other assessment tools –

* Three houses
* Observation
* Disability write their assessments from the ‘child’s point of view’ in the first person, which is very powerful (Cambs)
* Set questions
* Distance Travelled Tool – Early Help Assessment (Cambs)
* Early Help Assessment Tool Kit (Peterborough)
* Outcome Star (My Star and Team Star are the most common tools used)

**Safeguarding Quality Assurance**

SQA team have held briefing sessions with a number of practitioners and listed below are some of the tools that were suggested as being helpful to gain the lived experience of the child – for children and adolescents:

* Jenga (with questions written on the individual bricks in sharpie)
* The Rabbit Puppet
* The use of Graded Care Profiles and Genograms.
* Car Game and a board of questions and move the car around the Board answering questions as they go.
* Putting your worry’s into a box and addressing them with [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) over time.
* Skittles/Smarties game – Put sweets in a bowl, everybody picks a few out, different colours are different types of questions, answer the question eat the sweet.
* The use of Timelines and making them fun activities.
* Best venue for some appears to be the car journey.
* Visual Tools – Pictures of activities and likes / dislikes column to places pictures in, especially useful for children with additional needs.
* Eco-Maps / Genograms – with the use of photographs of family members and also asking children for their views of family members etc.
* Talking and drawing time – exploring the child’s own interests whilst discussing various points of home
* The use of cards games (Uno etc.) to build initial relationships and initiate discussion.
* Feelings card activities.
* Magic wand questions.

**Youth Offending Teams**

**Screening tools**

As part of assessment of risk and crimineogenic factors Asset+ has a section where the young person is asked how a statement is either like them or not like them. There is also a parents/carers self- assessment (all of these are available on the Youth Justice Resource Hub)

* Three houses
* MOMO
* Safety Plans – a written plan and agreement with the young person, parents and professionals regarding what to do if they need help / support (e.g. could be used for domestic violence / self-[harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and suicide)
* Emotional Health Assessment

Peterborough TYSS use MARS (My Acknowledged Risks and Strengths).  Tool which clarifies the young person’s views of their situation, clarifies the practitioners views (as informed by the ASSET +) and clarification of agreed issues between both young person and practitioner (i.e. your views, my views and our shared views). There is a further level to the tool which maps the keys strength and risks but with a clear picture of the young person’s motivation and confidence in either addressing the risk or sustaining the strength.

**Cambridgeshire and Peterborough Foundation Trust**

Three houses + adaptation of three houses to three islands / 3 caravans

**Establishing a Day in the Life of a School aged Child –** a prompt tool / checklist for practitioners to consider and ask a child about their day

**Feelings** – Words chart + Emojis for letting children and young people who how they are feeling

**Cambridgeshire and Peterborough Safeguarding Children Partnership Board**

http://www.safeguardingcambspeterborough.org.uk/children-board/children-and-young-people/ – safeguarding for children and young people

http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/ safeguarding for professionals

http://www.safeguardingcambspeterborough.org.uk/children-board/parents-carers/ safeguarding for parents

**Tools / Resources**

* *Child Neglect Tools*
  + Graded Care Profile Tool <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/child-neglect/>
  + Quality of Care Tool <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/child-neglect/>
  + Safeguarding children from Neglect leaflet for professionals and neglect resource materials / training <http://www.safeguardingcambspeterborough.org.uk/children-board/about/resources/>
* *Child Sexual*[*Abuse*](https://www.safeguardingcambspeterborough.org.uk/glossary/abuse/)
  + Brooke traffic light tool – <http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/06/Brook_Traffic_Light_Tool.pdf>
  + Pants Underwear Rule – [www.nspcc.org.uk/preventing-abuse/keeping-children-safe/underwear-rule/](http://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/underwear-rule/)
* *Self-*[*Harm*](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)*and Suicide*
  + Self- [Harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and Suicide strategy for schools <http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/08/Supporting-Schools-in-responding-to-Suicides-in-Teenagers.pdf>
* *Child Sexual Exploitation*
  + Resources for professionals <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/child-sexual-exploitation/>
* [*Domestic Abuse*](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/)*/ Violence*
  + Domestic Violence Risk Identification Matrix Tool <http://www.safeguardingcambspeterborough.org.uk/wpcontent/uploads/2019/03/Barnardos_DV_RIM.pdf>
* *Online Safety and Tools*
  + <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/onlinesafety/>

**Resources for Professionals**

* Including Training Slides, Briefings and useful information [**http://www.safeguardingcambspeterborough.org.uk/children-board/resources-for-practitioners/**](http://www.safeguardingcambspeterborough.org.uk/children-board/resources-for-practitioners/)

**SCPB Briefings**

[**http://www.safeguardingcambspeterborough.org.uk/children-board/resources-for-practitioners/**](http://www.safeguardingcambspeterborough.org.uk/children-board/resources-for-practitioners/)

* Sonia
* Voice of the Practitioner
* Themes and Lessons learned
* Eleanor
* Rachel’s Story

**Partner Agencies –**Do not forget the resources available within your own agency!

**Websites**

* For the ‘My World Triangle’ and additional associated resources for discussions with children, young people and families; <http://www.gov.scot/Topics/People/Young-People/gettingitright/national-practice-model/my-world-triangle>
* **Youthoria**. <http://www.youthoria.org/> A Cambridgeshire young people’s website for advice and support in a number of areas (school / health/ bullying / online safety etc);
* **Kooth** <https://kooth.com/> A confidential online service to support young people with their mental health and emotional [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/);
* **Keep Your Head**. <http://www.keep-your-head.com/> A hub with links and Apps to help young people cope with the pressures of life. (includes links to Bullying websites)
* **NSPCC** <http://nspcc.org.uk> – research fact sheets / resources for working with young people and areas for young people
* **Centre 33** <http://centre33.org.uk> free confidential help for those aged 25 and under. Sexual health, family problems, mental health, accommodation, money, benefits
* **NYAS** (National Youth [Advocacy](https://www.safeguardingcambspeterborough.org.uk/glossary/advocacy/) Service) NYAS – free independent [advocacy](https://www.safeguardingcambspeterborough.org.uk/glossary/advocacy/) service for young people (looked after, care leavers and those subject to child protection in Cambridgeshire, and looked after, care leavers only in Peterborough) Helpline 0808 808 1001; [help@nyas.net](mailto:help@nyas.net)   and [www.nyas.net](http://www.nyas.net)
* **CAFCASS**(National Service – Children and Family Court Advisory and Support Service). <https://www.cafcass.gov.uk/grown-ups/professionals/resources-for-professionals/> Have supportive materials available to engage with children and young people
* **Cambridgeshire and Peterborough**[**Domestic Abuse**](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/)**and Domestic Violence Partnership**<https://www.cambsdasv.org.uk/website>
* **Calm Zone** <https://www.childline.org.uk/toolbox/calm-zone/>
* **Me First**<https://www.mefirst.org.uk/> first is an education and training resource that helps health and [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) professionals to develop their knowledge, skills and confidence in communicating with children and young people

**Threshold policy**

This document is for everyone who works with children and young people and their families in Peterborough and Cambridgeshire. It is about the way we can work together, share information, and put the child, young person and their family at the centre of our practice, providing effective support to help them solve problems and find solutions at an early stage to prevent problems escalating*.*It sets out how we approach the difficult task of keeping children and young people safe and protected from [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

The guidance for threshold of need and intervention is a vital tool that underpins the local vision to provide targeted support services at the earliest opportunity – right through to specialist and statutory interventions when it is needed to promote the welfare and safety of vulnerable children and young people.  It aims to offer a clear framework and a common understanding of thresholds of need for practitioners within all agencies, to help to promote a shared awareness of the different interventions required to effectively support children, young people and their families or carers.

Protecting children and young people involves professionals in the difficult task of analysing complex information about human behaviour and risk. It is rarely straightforward and responses should be based on robust assessment, sound professional judgement and where appropriate statutory guidance.

All of us who work with children and their families will encounter situations where we can see that outcomes for children may be being affected by the actions or inactions of parents or carers. In most situations, this will mean that we should try to engage with the family and offer support to enable them to change their approach to parenting. It is almost always the case that those who know the child and family well will be in the best place to support families to change, or to access the support that they need and so to improve the outcomes for their children. This means that all of us working with children and young people will be working with and holding varying degrees of risk.

In Peterborough and Cambridgeshire, we want to ensure that all those professionals working with children and families are able to identify the help that is needed by a particular child and family as early as possible. Using their professional judgement along with this guide, practitioners will feel better equipped to direct families to appropriate resources at the appropriate time. This document is therefore intended to assist practitioners in identifying a child’s level of need and what type of service/resource may best meet those needs.

**Principles**

If we are to promote the best outcomes for children and young people, we should work to a set of common principles.

Children and young people almost always do best when they grow up within their own families. Even where risks of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) have been identified, it will usually be better for the child or young person to remain with their families and for their parents or carers to be supported to make the changes that they need to make in order that they are able to promote and safeguard the [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) of their children.

Parents may feel undermined or threatened whenever it is suggested that they may need additional help and support. Research also indicates that the way in which services engage with families can be a significant factor in how well support is accepted.

The principles below, together with those contained within Working Together 2018, are intended to underpin good practice and to increase the likelihood of support being offered to families being successful in securing improved outcomes for children:

**‘I have the right to be involved in plans that are being made about me…’**

In almost all circumstances, practitioners should discuss their worries about a child or young person with their parents or carers, before referring them on to another service. The only exceptions to this are circumstances where to do so would place anyone at additional risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and may lead to an offence being committed or make it more difficult for [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to be gathered that may support a conviction.

Where a child is **Gillick Competent** concerns about their [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) should also be discussed directly with them before any referral is made.

*Gillick competency essentially says that a child or young person of sufficient age and understanding is able to decide about what happens to them, and the right of a parent ‘yields to the child’s right to make his/her own decisions when he/she reaches sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring decision’.*

**‘I have the right to be treated as an individual and not on the basis of assumptions about my religion or cultural background…’**

If practitioners are in any doubt about the reasons why a family or individual is saying or appears to be behaving in a particular way, the best way to find out more is to ask the person concerned.

Many newly arrived families and individuals will be struggling to understand systems and processes in the UK, for example, they may have heard a number of stories about how children’s services take children away from their families. Practitioners need to be sensitive to these issues and take time to offer additional explanation and reassurance.

**‘I have the right to be able to talk about complicated things in my first language…’**

Ideally, practitioners should be able to speak directly in the first language of the individual. Working through interpreters is a more lengthy process and often affects the richness of the information being provided. However, many of our services do not have a workforce that matches the community being served in terms of diversity. This means that interpreters will be needed on occasion. Family members must not be used to interpret sensitive or complex matters.

**‘I can usually choose whether to accept the services you offer me …’**

People can refuse to accept support. In rare situations, a refusal to accept services may result in legal or other action being taken in order to ensure that very vulnerable children are safeguarded or protected, but these situations are limited to those where children are at risk of serious [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or injury. It is often the skill of people who are working with the individual or family and a recognition of why they may not want to accept support that will make the difference about whether they decide to engage with support services.

Families can sometimes refuse offers of support because they are worried that this might eventually lead to their child being ‘taken into care’. Practitioners working in this situation can only do their best to persuade people to accept support. One approach can be to seek agreement with the individual or the family where support may be helpful and seek agreement to address this specific issue and use this as a way of gaining trust.

Saying **NO** to prevention or early help services **DOES NOT MEAN** that specialist safeguarding services will become involved except where there is a risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child concerned or where they may present a significant risk to others. These risks usually need to be immediate, or be present within a short timeframe.

Where a family has declined to engage with prevention or early help services, practitioners must discuss their intention to refer to specialist services such as Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) with the parent [or young person if Gillick competent] before making the referral. This means that the parents or carers understand the possible consequences of not engaging with support services.

Specialist services will always inform those referred to them which professional has made the referral and why. [[1]](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/threshold-document/#_ftn1) Referring professionals should therefore be open and transparent about their concerns with parents and why they are so worried about their child, except where to do so would place the child or young person at risk of immediate [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).

**‘I do not want other people to know about me or my family unless I say that this is OK…’**

Unless it would put anyone at risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), we will always let people referred to us know, who we intend to talk to, about them. We always need talk to other professionals as well as people who know the person referred well, in order to make the right decision about what services to offer. We make a professional decision as to who it is necessary to share information with, on a case by case basis, making sure that this is legal, necessary and safe, particularly when we know information has been given in confidence.

It may not be possible to help people effectively if they do not want us to talk to others about them.

The records we make about people who are referred for services will be accessed only by staff who need to see them in order to do their jobs.

**‘Before you decide that I need help or support, you should ask me about what I think and who I know who may be able to help me….’**

It is important that children and their families feel in control of and have a say in the types of support they access. Support that is available from family and friends should also be explored because it is much more sustainable in the longer term than anything that an outside agency can provide.

**‘I may have other pressures in my life as well as the ones that you say you are worried about’**

Just as family and friends can be a real source of support, it is also important to consider where these relationships may place an additional pressure on the family or child, or lead to there being increased risks to a child’s [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/).

Mental health issues, substance misuse within the extended family, or other caring responsibilities can all increase stress or reduce availability to address other issues. It is therefore important for practitioners to consider the wider context before deciding what form of support may be most appropriate.

**THRIVE – a model for meeting children and families’ needs**

We recognise that each child and family member is an individual, and each family is unique in their make-up, so reaching decisions about levels of needs and the best intervention requires discussion, reflection and professional judgement.

This guidance seeks to give clear advice to all professionals and the public on the levels of need and thresholds for different services and responses in Peterborough and Cambridgeshire.

In this guidance we have identified three levels of need **Emerging Needs**, **Complex Needs** and **Specialist and Safeguarding Needs**.

**Emerging Needs**

Children and families with some emerging needs may require support of another service alongside universal provision to prevent an escalation of needs. An **Early Help Assessment**may be appropriate for some children at this level.

**Complex Needs**

Children and families with more significant complex needs and who are in need of targeted support without which they would not meet their expected potential. These children live in families where there is greater adversity and a greater degree of vulnerability. An **Early Help Assessment**and a **Team around the Family (TAF)** or **Team around the Child (TAC)** will be required.

**Safeguarding/Specialist Needs**

Specialist services are required where the needs of the child have been significantly compromised, they are suffering significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or impairment and statutory and/or specialist intervention is required to keep them safe.

A comprehensive statutory assessment under Section 17 of the Children Act will be required, intervention under Section 47 of the Children Act may be required for those children who are at immediate risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and legal action may need to be taken or the Local Authority may need to accommodate the child in order to ensure their protection.

The continuum of need model (windscreen) is a way of developing a shared understanding and explaining the Peterborough and Cambridgeshire approach across all our services and partnerships, ensuring a consistent response is applied by all.

The model illustrates how we will respond to the requirements of children and families across three levels of need **Emerging** **Needs, Complex Needs** and **Specialist and Safeguarding Needs**

In this model, all services and interventions seek to work openly with the family (or with young people on their own where it is appropriate) in order to support them to address identified needs at the right level of intervention. We recognise that this is never a static process, situations change and as a result so does the level of need and risk. We understand that children and young people may **“step up”** and need more specialist intervention and **“step down”** as interventions have impact and their needs and risks change as a consequence.

The Levels of Need table on pages **14 – 16**, and the Peterborough and Cambridgeshire continuum of need (windscreen) on page **13**together illustrate how support in Peterborough and in Cambridgeshire is delivered and clarifies the threshold between each level.

**Early Help:**

Early Help is about ensuring that children and families receive the support they need at the right time. We aim to provide help for children and families when problems start to emerge or when there is a strong likelihood that problems will emerge in the future. This means providing support early in life or early in the identification and development of a problem. Services in Peterborough and Cambridgeshire also recognise that some families will require additional help at various times of their lives and may need to access targeted services periodically to help re-build their resilience and capacity to manage. Support is also provided within the arena of Early Help when families have received specialist support and need a reduced level of support to sustain and continue the progress made.

**Early Help Assessments:**

We promote the use of the Early Help Assessment as the tool for recording the family’s unmet needs. The document should be a holistic assessment that captures the family’s strengths and needs. It should ask what is going really well? What is not going so well and causing some concern or worry? What do the family and those working with them think needs to happen, and what are the next steps to help that happen?

The Early Help Assessment is a single assessment that is created with the family. It should reflect their views, wishes and feelings and what they want to change. It is shared when appropriate [and where there is [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/)] with other professionals who are working in a co-ordinated way to support the family.

**Peterborough:**

Early Help Assessments are completed by any professional or partner agency who comes into direct contact with families, and who has identified more than one unmet need that would benefit from a multi-agency support approach. Early Help Assessments are initiated on an electronic case management system known as the Early Help Module or EHM. Training is provided for all professionals who might need to complete an Early Help Assessment with a family or contribute to one that another professional has started. Training to access the system is via an on-line learning package. To access this professionals should email register for an account at <https://www.peterborough.gov.uk/healthcare/early-help/liquidlogic-system-early-help-module-for-partners>

Professionals are advised not to delay starting an Early Help Assessment with a family whilst they await training, and should speak to a member of the Early Help Team for advice on how to proceed by emailing [earlyhelp@peterborough.gov.uk](mailto:earlyhelp@peterborough.gov.uk) or telephoning **01733 863649**.

**Cambridgeshire:**

Early Help Assessments are initiated on an electronic case management system known as the Early Help Module or EHM. Training is provided for all professionals who might need to complete an Early Help Assessment with a family or contribute to one that another professional has started. Training to access the system is via an on-line learning package. To access this professionals should email register for an account at <https://www.cambridgeshire.gov.uk/residents/children-and-families/parenting-and-family-support/providing-children-and-family-services-how-we-work/liquidlogic-system-early-help-module-for-partners>

Professionals are advised not to delay starting an Early Help Assessment with a family whilst they await training, and should speak to a member of the Early Help Hub for advice on how to proceed by emailing [early.helphub@cambridgeshire.gov.uk](mailto:early.helphub@cambridgeshire.gov.uk) or telephoning **01480 376 666.**

Further information can be found at <https://www.cambridgeshire.gov.uk/residents/children-and-families/parenting-and-family-support/providing-children-and-family-services-how-we-work/early-help-assessments>

Professionals who are thinking about completing an Early Help Assessment with a family are also encouraged to contact the relevant Early Help Service by email or telephone to discuss whether support from a single agency may be more appropriate:

Peterborough: [earlyhelp@peterborough.gov.uk](mailto:earlyhelp@peterborough.gov.uk) or 01733 863649

Cambridgeshire: [early.helphub@cambridgeshire.gov.uk](mailto:early.helphub@cambridgeshire.gov.uk) or 01480 376666

**Parental Consent**

The clear expectation is that all professionals will discuss their concerns openly and honestly with the child, where appropriate, and their parents or carers, except where to do so might place the child or another person at immediate risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or prejudice the prevention or detection of crime. Where this is the case, [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to refer concerns is not required and contact should be made with Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) as soon as possible. In emergency situations, contact should be made with the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/).

[Consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to make a referral will always be needed where a practitioner is requesting support of services on behalf of a child or family – this is regardless of whether they are seeking support from early help services or from Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) for child in need [Children Act 1989, Section 17] services.

If a family refuse prevention or early help services this does not mean that specialist safeguarding services will become involved. Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) will only become involved if there is a risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) to the child or where the information provided indicates that significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) is likely to happen if statutory intervention does not take place.

Where families are refusing to engage with early help services and where practitioners can see that there is the likelihood of a long term impact on outcomes for the child or young person, they should continue to engage with the family and seek to persuade them of the benefit of accessing additional support.

Where practitioners are concerned about the long term impacts of neglect on outcomes for a child or young person, they should consult with their safeguarding lead and can find more information from the Peterborough and Cambridgeshire Safeguarding Children Board Neglect Strategy. The strategy can be found by visiting the Cambridgeshire and Peterborough Safeguarding Board website <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/child-neglect/>[.](http://www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/)

**Information Sharing**

Working Together 2018 states that effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe. Child Safeguarding Practice Reviews (CPSR), formerly known as Serious case reviews (SCRs) have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children

It is important that practitioners can share information appropriately as part of their day-to-day practice and do so confidently.

It is important to remember there can be significant consequences in not sharing information as there can be in sharing information. You must use your professional judgement to decide whether to share or not and what information is appropriate to share.

Data protection law reinforces common sense rules of information handling. The law is there to ensure personal information is managed in a sensible way. It helps agencies and organisations to strike a balance between the many benefits of public organisations sharing information and maintaining and strengthening safeguards and privacy of the individual.

It also helps agencies and organisations to balance the need to preserve a trusted relationship between practitioner and child and their family with the need to share information to benefit and improve the life chances of the child.

The following are guidelines to help practitioners decide whether they should share information or not. They are based on the 2018 information sharing guidelines published by the government, with additional consideration of the Data Protection Act 2018 and the updated Working Together 2018:

1. Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Where possible, share information with [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), and where possible, respect the wishes of those who do not [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/), be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

**For further guidance on Information Sharing and Working Together please visit;**

|  |  |  |  |
| --- | --- | --- | --- |
| **Emerging Needs** | | | |
| **Description** | **What would we see?** | **Response** | **Outcome** |
| Children and families with some emerging needs which can be met within universal services. The emerging needs may require the support of another service, or worker, to prevent the escalation of needs.  An Early Help Assessment may be appropriate for some children at this Level.  Child’ with complex needs – needs limit their participation in community activities and their development would benefit from additional social and leisure activities | Secure and warm parenting  Guidance and boundaries in place  Network of support, adequate home environment, good school attendance, accessing health provision as needed  Age appropriate development and responses  Positive sense of self and developing age appropriate independence skills.  Parents may be struggling with a specific issue and require support.  Basic care may sometimes be inconsistent  Child’s level of needs limit their participation in community activities and their development would benefit from additional social and leisure activities. It may also have an impact on siblings/parents | Typically these children live in resilient and protective environments where their needs are met.  Children, young people, parents and carers can access universal services directly.  A child may require specific support in school; additional Health Visitor support may be required; or Children’s Centre group may be beneficial. | Children and young people make good progress in most areas of development  The life chances of children and families are improved by offering support |
| **Complex Needs** | | | |
| **Description** | **What would we see?** | **Response** | **Outcome** |
| Children and young people at this level have more significant emerging or complex needs and are in need of targeted support without which they would not meet their expected potential.  Their identified needs may relate to health, education, or social development and if unaddressed, they may develop into more worrying concerns. These children and young people will live in greater adversity and have a greater degree of vulnerability.  Targeted services, working alongside universal and preventative services, will be required.  Child with complex needs requires services to prevent impairment of health or development and/or alleviate stress in the family which may lead to risk in 3 or 4. | Parenting is inconsistent and parental issues may be getting in the way of meeting the child’s needs (mental health, learning disability, substance misuse).  There is a lack of parental guidance and age appropriate boundaries are not in place. Parents may be struggling to manage behaviour within the home and there may be some [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) of [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/).  The home environment may not always be adequate and the family may not have positive relationships within the community.  There may be issues with poor school attendance and behaviour when in class, health needs may not be met as appointments are often missed, there may be issues with anti- social behaviour, substance misuse, risk taking behaviour including early onset of sexual activity.  Parents need to provide significant care to other dependants who would otherwise be at risk OR child’s needs are significantly impacting on parents or social lives | An Early Help assessment will need to be completed.  If the outcome indicates a need for a multi-agency response. This will be offered with the [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) of the child/young person and family.  A Team around the Child (TAC) / Team around the Family (TAF) is also likely to be appropriate. Working with parents/carers and children will be essential to achieve the desired outcomes, and will require open discussion to progress targeted support.  Unless there is immediate risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) there is a clear expectation that Early Intervention will have been provided and a detailed review of what has been done/achieved/is outstanding will be provided in the written referral to Childrens [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/).  Support can be provided through Early Help / Disabled Children’s Early Help (if they receive High Rate DLA.) | Vulnerable children and families likely to face impairment to their development and life chances will be supported by services to enable them to achieve.  Issues will be prevented from escalating into safeguarding concerns requiring statutory intervention. |
| **Specialist Needs and Safeguarding** | | | |
| **Description** | **What would we see?** | **Response** | **Outcome** |
| Children and young people at this level are in need of specialist assessment and services.  These are children and young people with high complex needs who require a multi- agency assessment due to their level of disability  Children and young people where safeguarding can only be achieved by the involvement of specialist services. Although the family may still continue to receive support via preventative and targeted services alongside this.  They will require specialist assessment or immediate intervention, including accommodation. Examples of this include:   * all Section 47 referrals * children at risk of imminent family breakdown or where the breakdown has already occurred * young people remanded in LA care * a disabled child requiring specialist services to prevent immediate impairment or to prevent the need for long-term accommodation. | Child may have been abused or neglected; adults caring for the child are known or suspected of being a risk to children.  Parents have significant personal issues such as mental health, substance misuse or learning difficulties **which present a significant risk** to their child.  Family relationships are significantly conflictual and [domestic abuse](https://www.safeguardingcambspeterborough.org.uk/glossary/domestic-abuse/) is assessed as high risk (MARAC) and the child is at risk of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/).  The child’s medical needs have been significantly compromised due to parental neglect.  There is concern regarding a child under 13 being engaged in sexual activity.  Child may pose a significant risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)to others.  The home environment presents an immediate and serious environmental and health risk to the child. | At this level children and young people’s needs and care are significantly compromised. They are highly vulnerable and are experiencing high levels of adversity.  They have or are suspected to have acute/complex needs, and a comprehensive statutory assessment is required under Section 17 of the Children Act.  These children and young people may also be children in need of protection as they are experiencing significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) and are in immediate need of statutory intervention under Section 47 of the Children Act.  They may require legal action and may need to be accommodated. | Children and / or family members are likely to suffer significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) / removal from home / serious and lasting impairment without the intervention of specialist services, sometimes in a statutory role. |

* [**Working Together to Safeguard Children 2018**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)
* [**Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf)
* [**Data Protection Act 2018**](http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted)

**Peterborough and Cambridgeshire – Continuum of Need (Windscreen)**

Chart, radar chart, sunburst chart

Description automatically generated

**Level of Needs**

**Childrens Social Care**

Within Cambridgeshire and Peterborough all enquiries about children come through the Customer Service Centre and are directed through to the appropriate service. Any enquiries received where it is not clear whether there are safeguarding issues/risks will be passed through to Multi Agency Safeguarding Hub (MASH) for a MASH enquiry to be undertaken. This is a multi- agency team who undertake information gathering, analysis and decision making about whether there is a need for statutory intervention and if not what the appropriate intervention for the child, young person and their family might be.

**If you are concerned that a child is at immediate risk of**[**harm**](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)**:**

If a child is at immediate risk of significant or actual [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) you should complete the online [Safeguarding Children Referral Form](https://www.safeguardingcambspeterborough.org.uk/concerned/professionals-reporting-a-concern/)

To contact the MASH call:

* Cambridgeshire child: 0345 045 5203
* Peterborough child: 01733 864180
* EDT ([Emergency Duty Team](https://www.safeguardingcambspeterborough.org.uk/glossary/emergency-duty-team/)): (01733) 234724

The Customer Service Centre will ask for the child’s name and address, this enables them to check if the child or children already have an allocated social worker.  If there is an allocated social worker you will be directed to the relevant social worker or team manager.

If the child does not have a social worker, they will ask for:

* All the details known to your agency about the child including ethnicity, language spoken whether the child has any specific learning needs/disabilities
* Family composition including siblings including their names/dates of birth/schools attended
* The nature of the concern and your view of the immediate risks of significant [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/), what the impact is on the child and the [evidence](https://www.safeguardingcambspeterborough.org.uk/glossary/evidence/) to support this
* They will also need to know where the child is now and whether you have informed parents/carers of your concerns.

Based on the information provided they will consider the action to be taken for appropriate and proportionate intervention.

All telephone referrals will need to be followed up in writing within 24 hours by the referring professional.

The referring professional will be contacted and updated as to the outcome of their referral and what actions if any will be taken within one working day.

**If a child is not at risk of immediate**[**harm**](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)**but you have ongoing concerns about a child:**

If you believe that the child requires Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) intervention, you should follow your organisation’s internal safeguarding policy, speak with your line manager or safeguarding lead and consider the following points:

* All children, young people and their families should have had an opportunity to engage with Early Help support, before a referral is made to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/), and it is the expectation that an Early Help Assessment will have been considered/ completed and services put in place prior to a referral being made to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) where there are no immediate safeguarding concerns. You can contact Early Help Peterborough on 01733 863649 and the Early Help Hub Cambridgeshire on 01480 376 666 to discuss your concerns and explore what support from Early Help Services may be available and appropriate to meet a family’s needs.
* Have you gained [consent](https://www.safeguardingcambspeterborough.org.uk/glossary/consent/) or have you informed the parents that you are making a referral? If not you will need to do this, as Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) will be unable to progress your referral without this. **Remember that refusal to engage in Early Help support is not a reason for a referral to Children’s**[**Social Care**](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/)**except where this would result in a child suffering significant**[**harm**](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)**.**

When making a referral it is important that:

* All basic details are completed on the referral form ( correct names and spellings, siblings details, date of birth, addresses, ethnicity, first language, disabilities etc)
* The referral must clearly identify the concerns and the impact on the child as well as what support has been provided previously to help families address these concerns and what strengths/resilience is within the family.
* Referrals should set out what the referrer wants to see happen as a result of the referral, and should include the views of the family and, where appropriate, the child or young person.
* The more information that is provided, the easier it is for Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) to make a decision about the best course of action to take in respect of the child or young person.

**Other useful links;**

Professionals may find it useful to refer to some of the guidance and tools listed below when making a decision regarding how to progress concerns about a family.

[Making a good referral](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/11/CPSB-Good-and-Poor-Referrals-Guidance.pdf)

[Effective Support for Children and Families (Threshold) Document launch events presentation](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/12/Threshold-launch-Presentation.19.Nov_.18.pdf)

[Achieving the best outcomes for children and young people: Making the right referrals at the right time Multi-Agency Briefings](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2020/03/workshops-initial-slide-deck-versionfinal-website.pdf)

[Statutory guidance on Controlling and Coercive Behaviour in an intimate of family relationship.](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf)

[Pre-birth Assessment Guidance and flow chart](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/pre-birth_assessment/)

[Prevent & Safeguarding Guidance; Supporting individuals vulnerable to violent extremism](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2014/11/acpo-Prevent-and-Safeguarding-Guidance-Supporting-individuals-vulnerable-to-violent-extremism.pdf)

[Revised Prevent Duty Guidance for England and Wale](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf)[s](http://www.safeguardingpeterborough.org.uk/wp-content/uploads/2014/11/acpo-Prevent-and-Safeguarding-Guidance-Supporting-individuals-vulnerable-to-violent-extremism.pdf)

[Protecting Children from Radicalisation, the Prevent duty](https://www.gov.uk/government/publications/protecting-children-from-radicalisation-the-prevent-duty)

[Child Sexual Abuse Strategy](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-sexual-abuse-strategy-2021-2023/)

[Female Genital Mutilation Multi-agency Practice Guidance](https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/12/Practice-Guidance-for-practitioners-on-Female-Genital-Mutilation-2019.pdf)

[Child Exploitation Strategy](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/child-exploitation-strategy-2021-2025/)

[Neglect Strategy](https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2021/02/Neglect-Strategy-2018-21.pdf)

[Online Safeguarding Strategy](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/online-safeguarding-strategy-2021-2023/)

[Bruising in pre-mobile babies](https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/bruising-in-pre-mobile-babies-a-protocol-for-assessment-management-and-referral-by-professionals/)

[Sexual violence and sexual harassment between children in schools and colleges](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/667862/Sexual_Harassment_and_Sexual_Violence_-_Advice.pdf)

All the Cambridgeshire and Peterborough Safeguarding Children Board inter-agency Policies and Procedures can be found at the following link <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/lscbprocedures/>

**What to do if you do not agree with the MASH decision:**

**Key Principle:**It is every professional’s responsibility to “problem solve”.  The aim must be to resolve a professional disagreement at the earliest opportunity as swiftly as possible, always keeping in mind that the child and young person’s safety and welfare is the paramount consideration. The Safeguarding Board is clear that there must be respectful challenge whenever a professional or agency has concern about the **action or inaction**of another.

In the majority of cases most decisions are reached by consensus due to the multi-agency working within the MASH Hub. However, there may be occasions when professionals disagree. If this is the case the [**Resolving Professional Difference process**](http://www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/escalation_policy/) should be followed: <http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/escalation_policy/>

**Transfer of Responsibility for Children Who Move from One Local Authority’s Area to Another**

This protocol is about children in need, including those in need of protection, who move between Local Authority areas. This protocol does not cover children who go missing from home, or who go missing with their parents, or who go missing from care.

The basic principle that underpins these arrangements is that these are vulnerable children in need of multi-agency services and that the information about their needs should be available in whichever authority they reside. It applies to those cases where there is significant involvement by more than one agency. Timescales actions and responsibilities are set out under specific headings.

The expectation is that professionals from all agencies will promptly verbally notify and discuss with their counterparts, and that written or electronic information will follow at the earliest opportunity.

**Children to Whom This Protocol Applies**

When a child in need moves between Local Authority areas it is essential that the transferring authority (i.e. the one providing a service and holding information regarding the child and its family) notify the receiving authority (i.e. the one to which they move) of their concerns and the nature of their involvement and plans and do so in accordance with this protocol and with existing information sharing protocols.

This protocol applies to any child who is currently:

* Subject of a Child Protection Plan, or has been in the last six months.
* Subject of a Child In Need Plan.
* Subject of enquiries under Section 47 or Section 37 of the Children Act 1989 –including an unborn child.
* Subject of Police Protection, an Emergency Protection Order or a Prohibited Steps Order
* Formally assessed as a Child In Need under section 17 of the Children Act 1989.
* Subject of a Child and Family Assessment.
* Looked After – whether subject of a Care Order or Interim Care Order, or accommodated under section 20, or currently subject of Interim Care Proceedings.
* Privately fostered.
* Assessed as being at risk of significant harm.
* Subject of an allegation or concern in relation to an adult who works with children.

**Guidance**

Much of this guidance is addressed to staff in Children’s Social Care. However, all involved agencies should ensure that they give timely and appropriately comprehensive information to their counterparts in other areas when a child or family moves. Additional information is provided for health and education professionals at the end of this guidance.

**Child Subject of a Child Protection Plan**

Working Together 2018 sets the legal framework for these arrangements.

**Action to be taken by Children’s Social Care**

The transferring authority must provide the receiving authority with the Child Protection Plan and all reports from the previous conference 14 days prior to the move along with Core Group notes. If this is not possible because the move has already happened or is imminent, the information should be provided on the day the move becomes known about. The transferring authority should send these to the Contact Centre who will send through to safeguarding. An operational manager in the receiving authority should acknowledge acceptance verbally, or raise any questions or concerns about the proposed transfer, and in any event promptly confirm their position in writing.

The receiving authority should hold a transfer-in Child Protection Conference within 15 working days of their receipt of notification from the transferring authority. The date of the transfer-in conference and other arrangements for the conference should be notified to the transferring authority as soon as possible and confirmed in writing and efforts should be made to facilitate their attendance. The receiving authority should provide the transferring authority with details of each agency’s named staff in order that reports can be requested.

The following information should be shared in all circumstances.

* Any current assessment including risk assessments and Child and Family assessment.
* The current Child Protection Plan.
* Subject to the court’s permission any legal orders including interim orders.
* Subject to the court’s permission any court reports including section 7 or 37 reports.
* Subject to the court’s permission any expert reports in private law proceedings.
* An evaluation of the implications of the move including the effect on risk increase/decrease as a result of the move.
* Any identified special needs including health and education

In all cases the person responsible for maintaining records regarding children who are subject of child protection plans in the transferring authority must be notified on the day of the move, and they should then immediately inform the receiving area. This should be followed up in writing within 7 working days.

It is the transferring authority’s responsibility to ensure the child protection plan continues to be implemented until formal transfer has been agreed at a transfer-in conference. This includes core group activity and key worker responsibility. Actions may be taken by the receiving authority on behalf of the transferring authority, and this should be agreed at team manager level and recorded by both authorities.

There should be no significant change in the child protection plan until the receiving local authority has held a transfer in conference.

Please see Child Protection Conference Procedures.

**Temporary Move to Another Authority**

When a child subject to a Child Protection Plan moves to another Local Authority area temporarily for a finite period of time, the transferring/home authority should inform the receiving authority in line with Working Together to Safeguard Children (2018)

**Unaccompanied Asylum-Seeking Children (UASC)**

Under S17 of the Children Act 1989, the Local Authority has a general duty to safeguard and promote the welfare of children in their area. This includes unaccompanied asylum-seeking children who have no parent or guardian in this country. A UASC child provided with accommodation under S20 of the Children Act 1989 is a ‘looked after’ child.

The provision of alternative accommodation in other areas outside of the responsible Local Authority may provide additional protection to children at risk from traffickers. This option should be actively considered for those known to be at high end risk. EAST authorities should convene a working group to consider inter-authority arrangements.

**Child Subject To Section 47 Enquiries**

**Action to be taken by Children’s Social Care**

Where a child moves during the course of Section 47 enquiries the investigation should be completed by the authority that commenced the enquiries. The receiving authority must be notified of the enquiries as soon as the move, or any intention to move, is known. They should be involved in any subsequent strategy discussions to determine the way forward, but ownership of the enquiries should remain with the authority that began them.

If the outcome of Section 47 enquiries is that the child appears to be at risk of ongoing significant harm, the receiving authority should take responsibility for convening the Initial Child Protection Conference. They should do this within statutory timescales. The transferring authority should provide the receiving authority with a verbal report on the outcome of the enquiries on the day that the enquiries are completed and confirm this in writing at the earliest opportunity.

The receiving authority should also make enquiries as appropriate and should share these with the transferring authority to inform the overall assessment.

The family must be kept informed about transfer arrangements and be provided with the details of a named lead professional during the transfer period.

When there are ongoing section 47 concerns information must be shared about any adult who has been subject to MAPPA, MARAC or Integrated Domestic Abuse Programme (IDAP) arrangements and where there are current child protection concerns in relation to this person.

**Child in Need, Or Subject of Child and Family Assessment**

**Action to be taken by Children’s Social Care:**

The general principle that underpins these arrangements is that information is only to be shared when this has been explicitly agreed with the parents/carers, and child where appropriate. The exceptions are:

* When the outcome is to move into section 47 enquiries – in which case the guidance detailed above should be followed.
* When a court requests a report in private law proceedings and the child moves before the assessment has started. All previous information held by the transferring authority will be made available to the receiving authority. Court timescales must be adhered to.
* Where it is in the best interests of the child to do so in order to prevent significant harm, or serious impairment of health and welfare. Chapter 2 of Working Together to Safeguard Children 2018 is the guidance that informs those principles.
* When a child moves during the completion of an assessment the authority that commenced these assessments should complete them. There must be manager-to-manager discussions about the pragmatic arrangements for completing the assessment. The completion of the assessment would trigger a formal referral to the receiving authority where appropriate. Good practice would be that the receiving authority is a partner in the completion of the assessment. When it is clear that further social care intervention will be required these should be jointly agreed between the authorities. The receiving authority will assume case responsibility on completion when further actions are identified.

**Information to be shared:**

* Any assessment where child protection concerns have been identified but there is no ongoing risk of significant harm.
* Any assessment that identifies that a child has additional needs which require the intervention of social care.
* Previous child protection reports and minutes where a child has been deregistered within the last 6 months but continues to be a child in need
* Previous care plans where a child has been de-accommodated in the last three months.
* Any family support plan where a child has been in need of Social Care intervention and/or services, i.e. sponsored childcare, family support worker intervention, family centre attendance etc.

Children with disabilities are defined under section 17 as children in need. The Lead Professional involved with the child should identify what information should be shared.

Where children are in receipt of respite care but do not meet the ‘looked after’ children criteria, case responsibility will be with the receiving authority. Subject to appropriate consents all relevant information should be shared but the receiving authority may undertake a new assessment.

**Child who is subject of ongoing care proceedings or the subject of a care order and placed at home**

**Action to be taken by Children’s Social Care**

The information that must be shared between the authorities is contained within statutory regulations, and these must be followed. Where a child is subject of ongoing proceedings and the child lives outside of the authority that has conduct of the proceedings, the local authority where the child is resident must be informed. This applies in all cases whether the child is with family members or alternative carers. No reports in proceedings can be shared without the court’s permission. The protocol for joint care planning within care proceedings will always apply.

The following information must be shared in all circumstances:

* Notification of any child subject of a care or supervision order where the proceedings have concluded.
* Notification of any child subject of an interim order including an emergency protection order or a child subject of a section 8 order.
* Any known injunctions or bail conditions that pertain to the child subject to the proceedings or the carer of the child or any member of the child’s family.
* Any child who is subject to the no order principle.
* Any findings of fact against an adult in care proceedings.
* Any identified special needs, including Health and Education.
* Any other child of the household.

If a child with an EHCP for special educational needs moves into an area and the above criteria applies, the admission service and the area special needs officers must be informed to ensure the requirements of EHCP  is being met and any required alterations are made. For example, hours and type of support and the name of the school.

**Reporting Under Section 7 and Section 37**

If the Court has requested a Section 37 report, the authority where the child currently lives usually completes the final S37 or S7. However, the responsibility for completion of S37 lies with the Local Authority that has been directed by the Court to complete the report. If the child moves to another Local Authority during the time the reports are compiled and the Court had ordered the originating Authority to complete, this must remain with the originating LA. The Local Authority where the child moved to should be notified that the child is in their area and a referral for local support services needs to be made if required.

Section 7 reports can be completed by Local Authorities and Cafcass. If Cafcass complete the Section 7 report they must ensure they liaise with the Local Authority where the child currently lives but would seek background information from anywhere the child lived before. Timescales for reports must be adhered to and CiN plans can’t be closed before the report is filed in Court so there needs to be close collaboration between the two Local Authorities.

**Looked After Child**

The statutory regulations apply in all circumstances.

**Action to be taken by Children’s Social care**

For any ‘looked after’ child who is placed outside of their originating authority the following information must be shared in accordance with ‘Care Planning, Placement and Case Review Regulations 2010’ (England).

* Name of child/young person
* Date of birth
* Gender
* Name and address of parent/person with parental responsibility
* Child Protection Registration details
* Children with Disabilities Registration details
* Legal status
* Name and address of establishment, foster carer or organisation with whom the child/young person is placed
* Date of commencement of placement
* Placing Authority
* Name and address of social worker
* Details of any arrangement for another Authority/Person/Organisation to supervise or carry out the function in relation to the Placement, including name and address.
* Out of hours service contact telephone number
* Date of termination

The social worker overseeing the case should give formal written notification to the authority where the child is placed with details of the case accountable worker and their manager. This includes agency placements between authorities. The case accountable worker should also inform the designated health professional in the area in which the child is accommodated.

These arrangements apply to children in receipt of respite care that fall within the ‘looked after’ children criteria.

If the child is school age, the Virtual School must be informed to ensure the child is supported during the admission and integration process whilst introducing the child to their school or other education provision.

A register of Looked After Children coming to reside in the local authority from other Local Authorities will be electronically kept by the Conferencing and Review Service.

**Child Leaving Care**

This is the subject of national guidance and can be found in the Children and Social Work Act 2017. There are two national guidance documents following the 2017 Act: “Extending PA Support to all Care Leavers to Age 25” Feb 2018 and “Promoting the Education of Looked After Children and Previously Looked After Children” Feb 2018.

**Allegations Made By Children from One Local Authority Who Are Placed In Establishments / Placements in another Local Authority**

This applies to child-to-child allegations and all allegations against adults. All allegations in respect of adults who work with children must be reported to the Local Authority Designated Officer (LADO) in the county where the incident took place within one working day.

In all circumstances, case responsibility for a LADO referral will be held by the Local Authority where the incident took place. Strategy meetings or initial evaluation meetings will be chaired by a designated manager. Responsibility for managing enquiries will lie with the authority where the allegation is made. If information emerges during the course of the enquiry that the individual against whom an allegation is made additionally works with children in another Local Authority, that authority must be promptly informed, and information shared as appropriate. That Local Authority will have case responsibility in respect of the individual’s role in their area, but close working together with the originating authority will be necessary. The police authority where the alleged crime has been committed will investigate as appropriate. The placing authority will be immediately informed – initially verbally with written confirmation to follow. The social worker for the child will attend strategy meetings or initial/joint evaluation meetings as required. Case responsibility for the child will remain with the placing authority.

In the event there is evidence of multiple abuses the authority where the establishment/placement is based will be responsible for providing the resources to instigate the enquiry but will include all other relevant authorities. The procedures for dealing with complex abuse enquiries will apply. Where there is an allocated social worker for a child in these circumstances, they or their manager must remain involved in the investigation as appropriate in terms of attending strategy meetings and providing support to the child and their family. The actual investigation process may need to be independently conducted.

A series of strategy meetings may be required. In all circumstances there must be an action plan and this must be agreed between all agencies involved.

The final strategy meeting should ensure all agencies are clear that the actions that led to the investigation have been dealt with, minutes must be taken and circulated within 3 working days.

**Child on the Sex Offenders Register**

These children are covered by the public protection arrangements and the following information must be shared in all circumstances:

* The risk assessment completed by social care or other.
* The youth offending pre-sentence report.
* Any previous child protection reports or minutes relating to the perpetrator.

**Information Sharing In Special Circumstances**

There are circumstances for all agencies where it will be appropriate to share information about adults where there is reasonable cause to suspect that they may pose a risk to children. These will generally be adults whose behaviour is, or has been, of grave concern but who have not been convicted.

Bichard compliance is essential and legal advice should be sought in individual cases. Bichard compliance refers to the vetting procedures and recommendations from the Bichard Inquiry of 2004.

**Responsibilities of Health Professionals**

Information regarding children who meet the criteria outlined at the beginning of this protocol must be transferred between health trusts in a timely and appropriate manner. If a child is subject of a Child Protection Plan, or they are subject to a court order, or they are a child in need and subject of a plan – the records or information should be transferred directly to the office of the designated/named professional in the relevant trust.

If the Designated Office for Safeguarding Children receive the information, the office will forward this to the Named Professionals for Safeguarding Children within the community health service who will then take responsibility for the information and ensure it is passed to the appropriate health professional.

The caseload holder/trust/department in the receiving authority should be notified at the earliest opportunity by telephone of the family’s move. Colleagues in other agencies and health organisations who have contact with the family should be informed of the move and given up to date information. Practitioners from the transferring authority may be asked to provide a report or attend a transfer-in conference, this should be discussed and an agreement reached regarding a response that best meets the needs of the child/family.

In all other circumstances information should be shared following normal information sharing agreements.

Children who need a paediatric assessment should be seen at a site that meets both the needs of the child and the service. It is essential that there be discussion with the paediatrician prior to the assessment to agree appropriate action.

**Responsibilities of Education Professionals**

Any information relating to a child that meets the criteria described at the beginning of this protocol must be transferred between schools or other education settings in a timely and appropriate manner. If a child is subject of a Protection Plan or they are subject to a court order, or they are a child in need and subject of a plan, the child’s academic and all other records must be transferred to the named school and to other education services if they are to continue to be required/provided. Depending on the admission arrangements, contact should be made with the relevant admission service to ensure the child is registered at an appropriate school immediately. If it becomes known that a child has moved into an authority without a recent education history the child must be tracked through the Dept. of Education school 2 school service.

**Violent extremism**

**1. Introduction**

Radicalisation is defined as the process by which people come to support terrorism and violent extremism and, in some cases, to then participate in terrorist groups.

There is no obvious profile of a person likely to become involved in extremism or a single indicator of when a person might move to adopt violence in support of extremist ideas. The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame.

Three main areas of concern have been identified for initial attention in developing the awareness and understanding of how to recognise and respond to the increasing threat of children/young people being radicalised:

* Increasing understanding of radicalisation and the various forms it might take, thereby enhancing the skills and abilities to recognise signs and indicators amongst all staff working with children and young people;
* Identifying a range of interventions – universal, targeted and specialist – and the expertise to apply these proportionately and appropriately;
* Taking appropriate measures to safeguard the [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) of children living with or in direct contact with known extremists.

**2. National Guidance and Strategies**

The following are part of the government’s counter terrorist strategy, referred to as CONTEST.

[The Prevent Strategy: A Guide for Local Partners in England](http://www.education.gov.uk/publications/standard/publicationdetail/page1/288324). Stopping people becoming or supporting terrorists and violent extremists The expectation is that within all local authority areas a Prevent multi-agency partnership board is established to plan and manage responses. Children’s Services should be involved and participate in the Area Partnership Board for Prevent and kept informed of the particular risks in their area.

[Learning together to be safe: A toolkit to help schools contribute to the prevention of violent extremism](http://dera.ioe.ac.uk/8396/1/DCSF-Learning%20Together_bkmk.pdf). This provides guidance and advice on the importance of schools developing approaches to prevent violent extremism in children and young people within their existing work.

Working Together to Safeguard Children (WT) 2010 (now archived). Chapter 11 of WT 2010 identifies the risk of radicalisation to support terrorism and violent extremism as one of a number of factors which may make children and young people particularly vulnerable.

[Recognising and Responding to Radicalisation: Considerations for policy and practice through the eyes of street level workers](http://www.recora.eu/).

[Channel: Supporting Individuals vulnerable to recruitment by violent extremists: A Guide for local partnerships](https://www.gov.uk/government/publications/channel-guidance). The Channel programme is an initiative led by the [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) and operates in areas identified as having higher levels of risk, to provide support to those at risk of being drawn into violent extremism. The guidance identifies as good practice the importance of having:

* A clear referral process incorporating a multi-agency panel;
* An identified co-ordinator or location of expertise for advice, guidance and support;
* Information sharing protocols.

Cambridgeshire [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) operates a local Channel project which can provide advice and support to individuals at risk.

Steve Lodge is the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) lead and can be contacted at [steve.lodge@cambs.pnn.police.uk](mailto:steve.lodge@cambs.pnn.police.uk)

**3. Referral and Intervention Processes**

The NPCC guidance provides a model referral process for children and young people who are vulnerable to radicalisation and/or who may be at risk through living with or being in direct contact with known extremists.

[Click here to view model referral process flowchart](http://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/03/model_flow_ref_concerns_radical.pdf)[Diagram

Description automatically generated](http://www.safeguardingpeterborough.org.uk/wp-content/uploads/2018/03/model_flow_ref_concerns_radical.pdf)

Staff working with children should use this model to assist them in identifying and responding to concerns about children who may be vulnerable to being drawn into violent extremist activity.

Any member of staff who identifies such concerns, for example as a result of observed behaviour or reports of conversations to suggest the child supports terrorism and/or violent extremism, must report these concerns to the named or designated safeguarding professional in their organisation or agency, who will consider what further action is required. See also [Section 5, Understanding and Recognising Risks and Vulnerabilities of Radicalisation](http://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/supporting-children-and-young-people-vulnerable-to-violent-extremism/#5_Understanding_and_Recognising_Risks_and_Vulnerabilities_of_Radicalisation).

As set out in the flowchart, the named or designated professional must discuss any such concerns with the local [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/). After consultation with the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/)and in light of any further information gathered about the child and the family, if it is considered there are grounds for further involvement, a multi agency assessment meeting (usually involving the child, parents and relevant professionals) should be convened to determine the appropriate response and how this should be delivered.

The aim is to ensure an early identification of children’s vulnerabilities and promote a coordinated response, wherever possible within universal provision (Tier 1) or through targeted interventions (Tier 2) and the Early Help Assessment process. The emphasis should be on supporting vulnerable children and young people, rather than informing on or “spotting” those with radical or extreme views.

The attached table, [Appropriate, Proportionate Responses and Interventions](http://www.safeguardingpeterborough.org.uk/wp-content/uploads/2018/03/appropriate_resp_flow.pdf) (which has been reproduced from the NPCC Guidance) gives examples of the range of responses where concerns of radicalisation have been identified.

Diagram

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In exceptional cases, it may be considered that a child or young person is involved or potentially involved in supporting or pursuing extremist behaviour. This may be, for example, where the child is part of a family with known extremists (e.g. people who are currently subject to criminal proceedings or who have been convicted of terrorism related offences). Where this is the case, a referral must be made to Children’s [Social Care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) Services under the [Making Referrals to MASH Procedure](http://cambridgeshirescb.proceduresonline.com/chapters/p_recog_respond.htm) and the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) must be informed. Further investigation by the [police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) will be required, prior to other assessments and interventions.

While the nature of the risk may raise security issues, the process should not be seen as different from dealing with the likelihood of [Significant Harm](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/significant_harm.html) or vulnerability due to the exposure to other influences.

Consideration should be given to the possibility that sharing information about the concerns with the parents may increase the risk to the child and therefore may not be appropriate at the referral stage – see [Making Referrals to MASH Procedure](http://cambridgeshirescb.proceduresonline.com/chapters/p_recog_respond.htm).

Consideration should also be given to the need for an emergency response – this will be extremely rare but examples are where there is information that a violent act is imminent or where weapons or other materials may be in the possession of a young person or member of his or her family. In this situation a 999 call must be made.

Where there is involvement as a result of the concerns, any provision of services should be subject to regular reviews until it is deemed appropriate to end the agreed response.

**4. Local Support**

Locally, the following organisations are able to provide additional advice and guidance in relation to safeguarding individuals vulnerable to radicalisation and children who may be at risk through living with or being in direct contact with known extremists:

Key contacts within Cambridgeshire [Police](https://www.safeguardingcambspeterborough.org.uk/glossary/police/) are:

* Kevin Vanterpool ([Kevin.Vanterpool@cambs.pnn.police.uk](mailto:Kevin.Vanterpool@cambs.pnn.police.uk)); and
* Matt Newman ([Matt.Newman@cambs.pnn.police.uk](mailto:Matt.Newman@cambs.pnn.police.uk));
* Steve Lodge can provide advice and support for the Cambridgeshire Channel project ([steve.lodge@cambs.pnn.police.uk](mailto:steve.lodge@cambs.pnn.police.uk)).

**5. Understanding and Recognising Risks and Vulnerabilities of Radicalisation**

Children and young people can be drawn into violence or they can be exposed to the messages of extremist groups by many means.

These can include through the influence of family members or friends and/or direct contact with extremist groups and organisations or, increasingly, through the internet. This can put a young person at risk of being drawn into criminal activity and has the potential to cause [Significant Harm](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/significant_harm.html).

The risk of radicalisation is the product of a number of factors and identifying this risk requires that staff exercise their professional judgement, seeking further advice as necessary. It may be combined with other vulnerabilities or may be the only risk identified.

Potential indicators include:

* Use of inappropriate language;
* Possession of violent extremist literature;
* Behavioural changes;
* The expression of extremist views;
* Advocating violent actions and means;
* Association with known extremists;
* Seeking to recruit others to an extremist ideology;

**Whistleblowing**

**1. Introduction and Definition**

The importance of raising concerns at work in the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) or ‘whistle blowing’ is recognised by employers, workers, trade unions and the general public.

It is important for individuals to feel safe and listened to when raising concerns. An open approach to whistle blowing promotes the values of openness and transparency and encourages employees to treat service users with dignity, respect and compassion. In that way, the [wellbeing](https://www.safeguardingcambspeterborough.org.uk/glossary/wellbeing/) and safety of service users and the provision of good care become part of the culture, and are seen as “the way we do things around here”.

From the employer’s point of view, there are good business reasons for listening to workers who raise concerns, as it gives an opportunity to stop poor practice at an early stage before it becomes normalised and serious incidents take place. Whistle blowing has been shown to be an effective way to achieve service improvement, which has led to better practice.

From the workers’ perspective, the freedom to raise concerns without fear means that they have the confidence to go ahead and “do the right thing”. It is part of encouraging workers to reflect on practice as a way of learning.

**Definition:**

Whistle blowing is when someone who works in or for an organisation passes on information, which they reasonably believe shows wrongdoing or a cover-up by that organisation. For example, the information may be about activity that is illegal or that creates risks to the health and safety of others. The concern may relate to something that has happened, is happening or that a person may fear will happen in the future.

**2. Legal Requirements**

The law provides legal protection to workers who have been victimised at work or lost their job because they have ‘blown the whistle’.[1] To receive the legal protection, a whistleblower must:

* Be a ‘worker’ for the organisation about which they are whistle blowing;
* Reasonably believe they are acting in the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/);
* Whistle blow to either the appropriate people within their organisation or to a relevant third party, such as one that inspects or regulates the activity of that organisation.

The definition of ‘worker’ for whistle blowing purposes includes employees, temporary agency staff, home workers, trainees on vocational schemes, and those whose employment has ceased. It does not cover the self-employed, volunteers or foster carers. While these groups are not covered by the legislation that protects whistleblowers, their concerns would be listened to seriously and raised with the appropriate person responsible for the children’s [social care](https://www.safeguardingcambspeterborough.org.uk/glossary/social-care/) service/agency.

The [Public Interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) Disclosure Act 1998 (PIDA)[2] amends the Employment Rights Act 1996 (ERA)[3] by inserting Part IVA (protected disclosures) into the ERA. It offers protections to workers from any detriment from their employer that arises from the worker making a protected disclosure (‘a qualifying disclosure’). Disclosure is another word for whistle blowing.

To receive these protections, a worker must make a qualifying disclosure. This is any disclosure of information where:

* In the reasonable belief of the worker making the disclosure, it is made in the [public interest](https://www.safeguardingcambspeterborough.org.uk/glossary/public-interest/) and tends to show one or more of the factors outlined in section 43B of the PIDA, [www.legislation.gov.uk/ukpga/1998/23](http://www.legislation.gov.uk/ukpga/1998/23);
* The worker makes it to one of a number of specified persons outlined in sections 43C to 43F of the PIDA, [www.legislation.gov.uk/ukpga/1998/23](http://www.legislation.gov.uk/ukpga/1998/23);
* It may also be appropriate for a worker to make a disclosure under section 43G (disclosure in other cases), or section 43H (disclosure of exceptionally serious failure) of the PIDA.

Complaints and grievances are different to whistle blowing and other employing organisations’ policies and procedures should be followed.

**The Professional Duty of Candour for Health professionals:**

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/) or distress. This means that healthcare professionals must:

* Tell the patient (or, where appropriate, the patient’s advocate, [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) or family) when something has gone wrong;
* Apologise to the patient (or, where appropriate, the patient’s advocate, [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) or family);
* Offer an appropriate remedy or support to put matters right (if possible); and
* Explain fully to the patient (or, where appropriate, the patient’s advocate, [carer](https://www.safeguardingcambspeterborough.org.uk/glossary/carer/) or family) the short and long term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. Health and care professionals must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest and not stop someone from raising concerns.

[1] [Public Interest Disclosure Act 1998;](http://www.legislation.gov.uk/ukpga/1998/23/contents)  
[2] [www.legislation.gov.uk/ukpga/1998/23](http://www.legislation.gov.uk/ukpga/1998/23)  
[3] [www.legislation.gov.uk/ukpga/1996/18/contents](http://www.legislation.gov.uk/ukpga/1996/18/contents)

**3. What to do**

If a worker is unsure of what to do, there are a number of ways they can talk the matter over in confidence to decide how they would prefer to proceed:

* The union or [professional body](https://www.safeguardingcambspeterborough.org.uk/glossary/professional-body/);
* The independent whistle blowing charity [Public Concern at Work](http://trixresources.proceduresonline.com/nat_cont/contacts/public_concern.html);
* An independent legal advisor.

If the employer has a whistle blowing policy, the worker can refer to this. The Local Safeguarding Children Board for the area and the Local Authority may also have a whistle blowing policy to which the worker can refer. Whistle blowing directly to the services the concerns are about can result in a quick response as they have the power to act immediately on the concerns.

The worker can also whistle blow to the relevant regulatory body for example Ofsted, the GMC or HCPC. Similarly, the various Ombudsman offices can be contacted such as the [Parliamentary and Health Service Ombudsman](http://www.ombudsman.org.uk/); or the [Local Government Ombudsman](http://www.lgo.org.uk/).

Whichever point the worker decides to make the disclosure to, they will ask a number of questions so that they can determine how to proceed. It is therefore good planning to set down the concerns clearly to ensure that the matter is dealt with more speedily. Some of the questions that may be asked:

* Does the worker believe that a service user is at immediate risk of [harm](https://www.safeguardingcambspeterborough.org.uk/glossary/harm/)?
* To set out the facts;
* Do other workers share the concerns?
* Whether the concerns have already been raised with the employer and, if so, what the response was?
* What the workers views are about what should be done?

The organisation receiving the concerns must tell the worker what they will do next, what the likely timescale will be and establish a way to keep in contact with the worker. There may be issues of confidentiality which mean that the worker may not be provided with all details but a report of an outcome should be provided.

**4. Action by Regulatory Bodies and Employers**

The organisation will assess the information and determine the best way to investigate the concerns in a timely manner. The action they take will depend on the type of service the worker has contacted them about and what the concerns suggest is happening.

The organisation may have support services in place to support the worker while any enquiries are taking place.

The outcome of the investigation into the concerns should be shared with the worker bearing in mind any matters of confidentiality.

The organisation should regularly report all concerns raised (whether substantiated or not), the investigations and outcomes to the senior management / board of the organisation to raise awareness of the concerns, identify trends and ‘hot spots’, and ensure issues are being dealt with properly.

1. The Bromley Briefings published by The Prison Reform Trust December 2011 [↑](#footnote-ref-1)