**Annex 1**

**Specific Safeguarding**

**Abduction**

**Introduction**

Child abduction is the abduction or kidnapping of a child or baby by an older person. Several distinct forms of child abduction exist:

A stranger removing a child for criminal purposes: e.g. child sexual abuse, torture, murder, or for extortion - to elicit a ransom from the child's caretakers;

A stranger removes a child usually a baby, with the intent to rear the child as their own;

A parent removes or retains a child from another parent's care (often in the course of or after divorce proceedings).

Perhaps the most feared (but rare) kind of abduction is removal by a stranger. The most common form of abduction relates to parents removing or detaining a child from the other parent's care.

Sometimes this may involve taking a child abroad without the other parent's consent, or wrongfully detaining them in a foreign country following an overseas trip. If a parent takes or sends a child out of the UK without the permission of those with Parental Responsibility or the permission of the court this would be classed as child abduction. If a person has a Child Arrangements Orders for a child they will not be acting unlawfully if the child is taken or sent out of the UK for less than 4 weeks without the appropriate consent.

**Action to Safeguard**

If a practitioner is concerned that a child who is being abused or neglected may be taken out of the country and as a result s/he may suffer Significant Harm, the practitioner should contact Children's Social Care and the local Police immediately. The local authority may need to consider whether it should use its powers under the Children Act 1989 to safeguard the child. A practitioner seeking to protect such a child should consider the need for independent legal advice about immigration from an accredited lawyer. Consideration should be given to liaison with UK Visas and Immigration, not only about the child but also about the abusers and anyone seeking to smuggle a child out of the country. It will be relevant to consider:

Why is the child being taken out of the UK?

Will the care arrangements for the child in the UK allow the local authority to discharge its safeguarding duties?

What is the child's immigration status? Has the child recently arrived in the UK, and how did they arrive?

What are the proposed arrangements for the child in their country of destination? Is it possible to check these arrangements?

Are you satisfied that these arrangements will safeguard and promote the welfare of the child?

Take advice if you suspect that a child is at risk of Significant Harm, but you are not sure what to do, consult a manager, Named Professional, designated member of staff, or Children's Social Care. Similarly, seek advice if you are dealing with a culture that you do not understand.

**How the Police use the Law to Safeguard Children at Risk of Sexual Exploitation**

Section 2 of the Child Abduction Act 1984 states that where a person removes, detains or keeps a child away from a person who has lawful control of the child then that person is guilty of an offence. This could simply be that the child is in the person's house or company when parents think the child is elsewhere.

If the Police, in conjunction with other agencies suspect that a child is involved in an inappropriate relationship with an adult, but have no evidence to suspect any other criminal behaviour they may issue a warning under the Abduction Act. This warning in effect instructs the adult not to have any further contact with the child and informs them of the consequences should they choose to ignore it. This warning has been shown to be an effective tool in reducing the risks posed by some adults to children and removes any defence that person may have had to a prosecution under this legislation.

If there is reason to suspect that a child is being "groomed" for the purpose of sexual abuse the Police will arrest the adult detaining the child and commence an investigation.

In all cases where child abduction is suspected the Police should be contacted.

**Alcohol Misusing Parents/Carers**

**Alcohol Use in Pregnancy**

It has been suggested that that foetal alcohol syndrome is the biggest cause of non-genetic learning disability in the Western world and is the only one that is 100% preventable (McNamara, ibid).

"Not every child affected by prenatal alcohol exposure will experience severe learning disability, but learning disabilities are common... The primary... damage that alcohol exposure causes is to the central nervous system... it is important to emphasise that little is known about factors determining whether a child will develop alcohol-related problems, or how significant these will be.

There is no cut off point that indicates that a specific amount of alcohol at a specific time will create certain types of problems, and less will not... mothers who maintain adequate nutrition even though drinking may give birth to children less severely affected than mother's who have poor nutrition".

- Foetal Alcohol Syndrome website.

**The Child**

The effects on children of the misuse of alcohol by one or both parents or carers are complex and may vary in time, which is why a thorough assessment of needs and risk of harm is important. In some cases the misuse of alcohol may be one factor which, when linked to domestic violence or mental illness, may increase the risks to the child.

The circumstances of children must be carefully assessed not only to consider immediate risks but also the long-term effects on the child of their parents' alcohol misuse.

The children of parents who misuse alcohol are at increased risk of developing alcohol problems themselves and of being separated from their parents. Research demonstrates that children who themselves start drinking at an early age are at greater risk of unwanted sexual encounters and injuries through accidents and fighting.

**Intra Concerns**

The health and development of an unborn child may be affected by the parent's alcohol misuse and newborn babies may suffer foetal alcohol syndrome which as a result may interfere with the parent/child bonding process.

Babies may experience a lack of basic health care and poor stimulation and older children may experience poor school attendance, anxiety about their parents' health and taking on a caring role for the parent or siblings.

The parent's practical caring skills can be affected by the misuse in the following ways:

Lack of attention to basic physical needs;

Lack of control of emotions;

Impaired judgement.

**Referrals**

Professionals, when confronted with a child in an alcohol-misusing environment must ask themselves "What is it like for a child in this environment?"

The Common Assessment Framework will assist in determining the level of vulnerability of the child and at what point a referral is made to Children's Social Care - see Making a Referral to Children's Social Care.

Information gathered during a Common Assessment should form the basis for the referral including relevant multi agency Referral Forms.

**Assessment and Initial Child Protection Conference**

Children's Social Care will consider whether it is appropriate to undertake a Single Assessment in relation to all Referrals.

In these circumstances Single Assessments will consider and take account of whether the person concerned is hiding or denying their alcohol misuse; whether they are engaged in any rehabilitation programme; whether they receive support from a partner, family or friends; the impact of the alcohol misuse on the quality of care given to the child and the day-to-day environment of the child as well as the long term impact on the child.

Throughout the assessment process and where it is decided to call a Strategy Discussion, undertake a Section 47 Enquiry and convene an Initial Child Protection Conference, those agencies who have worked with the parents in relation to their alcohol misuse must be asked to contribute and invited to participate in and attend relevant meetings.

If the concerns are in relation to an unborn child, the maternity services must be invited to attend the Strategy Discussion, and involved in any Section 47 Enquiry, Initial Child Protection Conference and, where appropriate, the Core Group.

**Breast ironing (also called breast flattening)**

is when young girls' breasts are damaged over time to flatten them and delay their development. Sometimes, an elastic belt, or binder, is used to stop them from growing.

Breast ironing usually starts with the first signs of puberty and is most often done by female relatives. In most cases, the abuser incorrectly thinks they're behaving in the best interests of the child. They believe flattening the breasts will make the child less 'womanly'. They hope this will protect the girl from harassment, rape, abduction and early forced marriage, and help them stay in education.

Breast ironing can cause serious physical issues such as:

* abscesses (a painful collection of pus that develops under the skin)
* cysts (fluid-filled lumps under the skin that can develop into abscesses)
* itching
* tissue damage
* infection
* discharge of milk
* breasts becoming significantly different shapes or sizes
* severe fever
* the complete disappearance of one or both breasts

Although there's no specific law within the UK around breast ironing, it's a form of child abuse.

Find out what the signs of this abuse are, what you can do if you’re concerned about someone and how to get help if you’ve been affected.

Signs and symptoms of breast ironing

There are many signs that breast ironing could be happening to a girl. These include:

* avoiding medical examinations
* not wanting to get undressed in front of anyone
* difficulty lifting their arms as the breast area will be tender to move and touch
* walking or sitting hunched over
* some girls may ask for help, but may not say exactly what the problem is because they're embarrassed or scared
* unusual behaviour after time away from school or college including depression, anxiety, aggression and withdrawal
* a girl is withdrawn from PE and/or sex and relationship education classes

**Bullying**

**Definitions**

The government has defined bullying as: "Behaviour by an individual or group, usually repeated over time, that intentionally hurts another individual or group either physically or emotionally" and cyberbullying as: "The use of Information Communications Technology (ICT), particularly mobile phones and the internet, deliberately to upset someone else". See also Online Safeguarding Procedure;

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

Physical;

Verbal;

Emotional.

Increasingly, information technology is being used as a means of communicating verbal and emotional bullying.

Bullying often starts with apparently trivial events such as teasing and name calling which nevertheless rely on an abuse of power. Agencies working with incidents of bullying should consider whether there are any child protection issues to be considered and whether a Referral to Children's Social Care is necessary in relation to the child bully, (see Action Taken When a Child is Referred to Local Authority Children's Social Care Services Procedure) the child victim or both, including under the Peer Abuse Procedure.

**Impact of Bullying on the Child**

Any child may be bullied, but bullying often occurs if a child has been identified in some ways as vulnerable or different to the majority. They may also be inclined to spend more time on their own.

Children living away from home are particularly vulnerable to bullying and abuse by their peers.

The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them Significant Harm (including self-harm). See Self-Harm or Suicidal Ideation Procedure

Children are often held back from telling anyone about their experience either by threats or 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, or becoming withdrawn and isolated.

**Action to Safeguard**

All settings in which children are provided with services or are living away from home should have in place rigorously enforced 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.

The following principles will apply:

A sense of community will be achieved only if organisations take seriously behaviour which upsets children;

Recognition of each child's individual needs will reduce the likelihood of them becoming isolated and vulnerable and, where it is a residential setting, supports them to adapt to their living arrangements;

Friendships between children should be nurtured;

Support should be offered to children for whom English is not their first language to communicate needs and concerns;

Support should also be offered to children who have any difficulties in communicating as a result of a learning and/or physical disability - see also Disabilities and Learning Difficulties Procedure;

Children should be able to approach any member of staff within the organisation with personal concerns in the knowledge that the staff will respond appropriately.

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:

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.

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.

**Children from Abroad (including Unaccompanied and Separated Children and the International Tracing and Messaging Service)**

**Introduction**

Large numbers of children arrive into this country from overseas every day. Many of these children do so legally in the care of their parents. There are many reasons for their arrival including the expansion of the global economy and incidence of war and conflict. Recent evidence indicates that many children are arriving into the UK who are:

Accompanied: Whilst there are many legitimate reasons for children to be brought into the UK such as, education, reunification with family or fleeing a war torn country, little is known about this group of children:

They may be:

In the care of adults who, whilst they may be their carers, have no Parental Responsibility for them;

In the care of adults who have no documents to demonstrate a relationship with the child;

In the control of traffickers/agents.

Unaccompanied: More is known about this group of children as most come to the attention of the authorities when they claim asylum although some "disappear".

Unaccompanied children or those accompanied by someone who is not their parent are particularly vulnerable; a point that is clearly made in the Second Joint Chief Inspector's Report Into Safeguarding Children. Many of these children and their carers will need assistance to ensure that the child receives adequate care and accesses health and education services;

Safeguarding and promoting the welfare of these children must remain paramount with agencies in their dealings with this group. Where there are concerns for the welfare of a child who has arrived in the region from abroad, every effort should be made to obtain information about the child and family from the child's country of origin.

**The Legal Position**

Immigration legislation impacts significantly on work under the Children Act 1989 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 etc. All practitioners need to be aware of this context. Legal advice on individual cases will usually be required by Children's Social Care;

Local authorities should carry out a Single Assessment where appropriate for every child referred to them by Immigration Services, regardless of their immigration status. Based on this assessment local authorities have a duty to provide appropriate support and services to all UASC, as these children should be provided with the same quality of individual assessment and related services as any other child presenting as being a Child in Need.

**Unaccompanied Asylum-Seeking Children (UASC)**

An UASC is a child who is applying for asylum in their own right and is separated from both parents and is not being cared for by an adult who in law or by custom has responsibility to do so;

Consideration should be given to providing services under Section 20 where accommodation is required. Once UASC become accommodated children under Section 20 of the Children Act 1989, they are required to be the subject of a Care Plan and, if over 16, a Pathway Plan. The plan must be based on this comprehensive assessment of their needs, taking account of the following dimensions:

Health (including mental health, such as whether post-traumatic support and counselling if needed);

Education - what has school meant to this child?

Emotional and behavioural development;

Identity and age;

Family and social relationships;

Social presentation;

Self-care skills, including the child's understanding of the implications of their immigration status and the skills required to manage transitions.

The responsible local authority should provide services for the UASC on the basis of the above assessment, irrespective of their immigration status;

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;

In addition, unaccompanied children should be informed of the availability of the Assisted Voluntary Return Scheme.

**Establishing the Child's Identity and Age**

Care of Unaccompanied Migrant Children and Child Victims of Modern Slavery: Statutory guidance for local authorities (DfE, 2017) provides that where the age of a person is uncertain and there are reasons to believe that they are a child, they are presumed to be a child in order to receive immediate access to assistance, support and protection in accordance with section 51 of the Modern Slavery Act 2015. 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. Where age assessments are conducted, they must be Merton Compliant;

Citizens of EU countries will have passport or ID card (usually both). Unaccompanied children very rarely have possession of any documents to confirm their identity or even to substantiate that they are a child. Their physical appearance may not necessarily reflect his/her age;

The assessment of age is a complex task, which often relies on professional judgement and discretion. Such assessment may be compounded by issues of disability. Moreover, 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;

In advance of undertaking an age assessment for an unaccompanied asylum seeking child, local authorities must seek Home Office assistance with verifying the authenticity of identity documents e.g. travel documents or a birth certificate. See further information and contact details for local authorities: Age Assessment Guidance and Information Sharing Guidance for UASC.

**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 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 form is voluntary. The content does not, nor does it seek to, be binding on local authorities. It is simply a recommended approach.

Introduction to Joint Working Guidance;

Age Assessment Information Sharing for Unaccompanied Asylum Seeking children: Explanation and Guidance;

Joint Working Guidance;

Age Assessment Information Sharing Proforma.

**Children Living Away from Home (including Children and Families living in Temporary Accommodation)**

**Introduction**

Revelations of the widespread abuse and neglect of children living away from home have done much to raise awareness of the particular vulnerability of children living away from home. Many of these revelations have focused on sexual abuse, but physical and emotional abuse and neglect - including peer abuse, bullying and substance misuse - are equally a threat in institutional settings.

Concern for the safety of children living away from home has to be put in the context of attention to the overall developmental needs of such children, and a concern for the best possible outcomes for their health and development. Every setting in which children live away from home should provide the same basic safeguards against abuse, founded on an approach that promotes their general welfare, protects them from harm of all kinds, and treats them with dignity and respect. These values are reflected in regulations and in the National Minimum Standards for Children's Homes, which contain specific requirements on safeguarding and child protection for each particular regulated setting where children live away from home.

Procedures for safeguarding and promoting the welfare of children apply in every situation, and to all settings, including where children are living away from home. Individual agencies that provide care for children living away from home should have clear and unambiguous procedures to respond to potential matters of concern about children's welfare in line with the procedures in Part 3, Managing Individual Cases where there are concerns about a child's safety or welfare.

**Essential Safeguards**

There are a number of essential safeguards that should be observed in all settings in which children live away from home, including foster care, residential care, Private Fostering, armed forces bases, healthcare, boarding schools (including residential special schools), prisons, Young Offenders' Institutions, Secure Training Centres and secure units. Where services are not directly provided, essential safeguards should be explicitly addressed in contracts with external providers.

These safeguards should ensure that:

Children feel valued and respected and their self-esteem is promoted;

There is openness on the part of the institution to the external world and to external scrutiny, including contact with families and the wider community;

Staff and foster carers are trained in all aspects of safeguarding children, alert to children's vulnerabilities and risks of harm, and knowledgeable about how to implement safeguarding children procedures;

Children who live away from home are listened to, and their views and concerns responded to;

Children have ready access to a trusted adult outside the institution - e.g. a family member, the child's social worker, or children's advocate. Children should be made aware of the help they could receive from independent advocacy services, external mentors and ChildLine;

Staff recognise the importance of ascertaining the wishes and feelings of children and understand how individual children communicate by verbal or non-verbal means;

There are clear procedures for referring safeguarding concerns about a child to Children's Social Care;

Complaints procedures are clear, effective, user-friendly and are readily accessible to children and young people, including those with disabilities and those for whom English is not their preferred language. Procedures should address informal as well as formal complaints. Systems that do not promote open communication about 'minor' complaints will not be responsive to major ones, and a pattern of 'minor' complaints may indicate more deeply seated problems in management and culture that need to be addressed;

Records of complaints should be kept by providers of children's services - e.g. there should be a complaints register in every children's home that records all representations or complaints, the action taken to address them and the outcomes. Children should genuinely be able to raise concerns and make suggestions for changes and improvements, which should be taken seriously;

Bullying is effectively countered;

Recruitment and selection procedures are rigorous and create a high threshold of entry to deter abusers;

There is effective supervision and support that extends to temporary staff and volunteers;

Contractor staff are effectively checked and supervised when on site or in contact with children;

Clear procedures and support systems are in place for dealing with expressions of concern by staff and carers about other staff or carers. Organisations should have a code of conduct, instructing staff on their duty to their employer and their professional obligation to raise legitimate concerns about the conduct of colleagues or managers. There should be a guarantee that procedures can be invoked in ways that do not prejudice the 'Whistle-blower's' own position and prospects;

There is respect for diversity, and sensitivity to race, culture, religion, gender, age, sexual orientation and disability;

Staff and carers are alert to the risks of harm to children in the external environment from people prepared to exploit the additional vulnerability of children living away from home.

**Children in Foster Care**

Where children are cared for in foster care placements it involves children being in the private domain of carers' own homes. It is important that children have a voice outside the family. Social Workers are required to see children in foster care on their own (taking appropriate account of the child's views), and evidence of this should be recorded.

Carers should be provided with full information about the child and his/her family, including details of abuse or possible abuse, both in the interests of the child and of the foster family.

Carers should monitor the whereabouts of the children they care for, their patterns of absence and contacts. Foster carers should follow the recognised procedure of their agency whenever a child placed with them is missing from their home. This will involve notifying the placing authority and where necessary the Police of any unauthorised absence by a child.

The procedures in Part 3 of the manual relating to Managing Individual Cases where there are concerns about a Child's Safety or Welfare, apply on the same basis to children in foster care as they do to children who live within their own families. In addition any allegations should be dealt with in line with the Allegations Against Persons who Work with Children (including Carers and Volunteers) Procedure. In these circumstances, Section 47 Enquiries should consider the safety of any other children living in the household, including the foster carers' own children. The local authority in which the child is living has the responsibility to convene a Strategy Discussion, which should include representatives from the responsible local authority that placed the child. At the Strategy Discussion it should be decided which local authority should take responsibility for the next steps.

**Children Placed for Adoption**

There is a particular vulnerability about children who are placed for adoption but not yet adopted in that they are almost, but not quite in the category of no longer Looked After, and there is a risk that safeguarding concerns in respect of the prospective adoption may be missed. It is very common for these children to be placed at a significant distance from their home authority, making intense monitoring of the placement more challenging.

Where an allegation of abuse or neglect is made in respect of a child placed for adoption or in respect of a prospective or approved adopter, the following actions must be taken:

Where a child is placed with prospective adopters, a prompt referral must be made to the placing authority and/or local authority where the child is placed (if different) if any allegation of abuse or neglect is received, in order for it to be investigated under that authority's procedures;

Where Section 47 Enquiries are made in respect of a child by the local authority where they are placed, full co-operation must be given by any other authority with information about that child;

Where the child is not placed with prospective adopters, there must be a prompt referral to the local authority where the main office of the Adoption Agency concerned is based, in respect of any allegation of abuse or neglect relating to the prospective adopters;

The Regulatory Authority must be notified of the instigation and outcome of any Section 47 Enquiry;

Consideration must be given as to the implications of the outcome of any allegation, and any necessary measures taken in order to protect children placed with prospective adopters in line with the Allegations Against Persons who Work with Children Procedure (including Carers and Volunteers);

Adoption agencies must ensure that appropriate individuals working for the purposes of the agency, prospective adopters and children placed by the agency have access to any necessary information to enable them to contact local authority where a child is placed, plus the Regulatory Authority in respect of any concern about child welfare or safety relating to an adoptive placement.

**Children in Residential Settings**

All residential settings where children and young people are placed, including children's homes and residential schools, whether provided by a private, charitable or faith based organisation, or a local authority, must adhere to the Children's Homes Regulations 2001 and all other relevant regulations and to the relevant Quality Standards.

Clear records must be kept and reviews and inspections must take place in accordance with Quality Standards and regulations.

All such establishments must have in place complaints procedures for children and young people, visiting and contact arrangements with social workers and Independent Visitors (for looked after children), as well as parents, advocacy services.

Social Workers have a legal duty to see children in residential care who are looked after, and evidence of this should be recorded on the child's records.

Where there is reasonable cause to believe that a child in a residential setting has suffered or is at risk of suffering Significant Harm, a referral must be made to Children's Social Care in accordance with the Referral Procedure. The concerns may range from bullying or abuse by other children to allegations against staff - see Bullying Procedure, Peer Abuse Procedure and, where the concerns relate to a member or members of staff and/or the care the child is receiving in the residential setting, the Allegations Against Persons who Work with Children (including Carers and Volunteers) Procedure will apply and a Strategy Meeting will be held.

When the concerns relate to a looked after child placed in residential care outside the area of the responsible local authority - see Transfer Across Local Authority Boundaries Procedure.

Where the concern arises in relation to a looked after child's placement, the local authority for the area where the child is placed also has responsibility to ensure that other local authorities who also have placed children in the same residential setting are aware of the concern or allegation and that consideration is given to protection of other children in the placement. They should also inform the Regulatory Authority.

**Children of Families Living in Temporary Accommodation**

Placement in temporary accommodation, often at a distance from previous support networks or involving frequent moves, can lead to individuals and families falling through the net and becoming disengaged from health, education, social care and welfare support systems. Some families who have experienced homelessness and are placed in temporary accommodation by local authorities under the main homeless duty can have very transient lifestyles. It is important that effective systems are in place to ensure that the children from homeless families receive services from health and education as well as any other specific types of services because these families move regularly and maybe at risk of becoming disengaged from services.

Where there are concerns about a child or children the procedures in Part 3 of the manual relating to Managing Individual Cases where there are Concerns about a Child's Safety or Welfare should be followed.

If any professional is made aware that the temporary accommodation being provided for a child is unsuitable they should follow their agencies internal procedures in respect of notifying the local authority housing department of the need to take action.

**Complex (Organised or Multiple) Abuse**

**Introduction**

Complex (organised or multiple) abuse may be defined as abuse involving one or more abusers and a number of children. The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework or position of authority to recruit children for abuse.

Organised and multiple abuse occur both as part of a network of abuse across a family or community and within institutions such as residential homes or schools. Its investigation is time consuming and demanding work requiring specialist skills from both Police and social work staff. Some investigations become extremely complex because of the number of places and people involved, and the timescale over which the abuse is alleged to have occurred.

The complexity is heightened where, as in historical cases, the alleged victims are no longer living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. Cases of historical abuse often come to light when adults disclose abuse they suffered as children whilst living away from home. Such cases should be responded to in the same way as any other concerns. It is important to ascertain if the alleged perpetrator is still working with,or caring for children.

The Children's Social Care, in the area where the alleged incident took place, has case responsibility and should arrange a Strategic Planning Meeting to determine any further action required.

**Action to Safeguard Children**

Each investigation of organised or multiple abuse will be different, according to the characteristics of each situation and the scale and complexity of the investigation. Each requires thorough planning, good inter-agency working and attention to the needs of the children involved. The guidance, Complex Child Abuse Investigations: Inter-Agency Issues seeks to help agencies confronted with difficult investigations by sharing the accumulated learning from serious case reviews.

Once organised abuse is suspected, the Children's Social Care and/or Police must be informed as soon as possible. Within Children's Social Care, the relevant Manager must be informed. Other agencies should not make any further enquiries. The Police and Children's Social Care will liaise at senior management strategic level to consider the following issues:

The overall scope and management of the case, including the handling of political and media issues;

The deployment of appropriate resources and the support staff;

The need to establish a dedicated joint team who can conduct the criminal investigation and Section 47 Enquiries objectively;

A process of strategic review to oversee the whole investigation and to identify and act on lessons learned for future policy and procedure and practice;

A programme of Strategic Planning Meetings should be established to agree:

Terms of reference and lines of accountability and communication;

Sharing of information, access to, and secure storage of records. See also Information Sharing & Confidentiality Procedure;

Access to legal advice regarding the criminal, civil and employment processes;

Whether there are any children involved who need active safeguarding and/or therapeutic help;

How safeguarding and help can be achieved in a way consistent with the conduct of the criminal

investigations;

How victims' needs will be assessed and met;

How care for the investigating team can be provided;

How, at the end of the investigation, it can be assessed and lessons learned for the future.

**Process of the Investigation**

In all major investigations the LSCB organisations will aim to:

Bring together a trusted and vetted team from Police and social work (Children's Social Care or NSPCC or both) to manage and conduct major investigations where a criminal investigation runs alongside child protection enquiries;

Set out clearly the terms of engagement for the team, emphasising the need for confidentiality;

Ensure that the managers of the team have training and expertise in conducting investigations, legal processes, disciplinary proceedings, children's welfare and profiles and methods of abusers (in cases of sexual abuse);

Ensure team members have expertise in conducting investigations, child protection processes and children's welfare and are committed to working closely together;

Involve senior managers from involved agencies at a strategic level. The Police will appoint a Senior Investigating Officer of appropriate rank and experience;

Ensure that appropriate resources are deployed and staff supported;

Agree upon the handling of political and media issues arising from investigations;

Ensure that records are safely and securely stored;

Recognise and anticipate that an investigation may become more extensive than suggested by initial allegations;

Ensure independence and objectivity on the part of the social work team, where Children's Social Care staff or foster carers are being investigated;

Where it is practicable in the circumstances to conduct a rigorous and impartial investigation using the local authority's own staff, ensuring sufficient distance (in structural and geographical terms) between such staff and those being investigated This means that the inclusion of staff members or managers from the institution or workplace under investigation should be considered with particular care;

Begin every investigation with a Strategic Planning Meeting to agree terms of reference and ways of working. Relevant areas for decision-making include the timing, parameters and conduct of the investigation; lines of accountability and communication; the safe and secure storage of records; the deployment of staff and resources; and a communications strategy encompassing members of staff, children and families, and the media;

Terms of reference should include assurances that the team will have full access to records and individuals that hold important information;

Secure access to expert legal advice. The inter-relationship between criminal, civil and employment processes is complex;

Use regular Strategic Planning Meetings and reviews to consider the conduct of the investigation, next steps and the effectiveness of joint working;

Always minute meetings and records actions that have been agreed with timeframes;

Agree clear written protocols between the Police, Children's Social Care and other agencies in relation to all key operational and policy matters including information sharing. See Information Sharing & Confidentiality Procedure;

Consider first whether there are any children involved who need active safeguarding and/or therapeutic help and how this should be achieved in a way that is consistent with the conduct of criminal investigations;

Make a thorough assessment of victims' needs and provide services to meet those needs;

Provide a confidential and independent counselling service for victims and families;

Agree guidelines with counselling and welfare services on disclosure of information to avoid the contamination of evidence;

Provide welfare and support for the investigation team - much of the work may be difficult and distressing;

Put in place a means of identifying and acting on lessons learned from the investigations (e.g. in respect of policies, procedures and working practices which may have contributed to the abuse occurring) as the investigation proceeds and at its close and at the conclusion of the investigation assess its handling and identify lessons for conducting similar investigations in future;

At the conclusion of the investigation assess its handling and identify lessons for conducting similar investigations in future.

**Concealed or Denied Pregnancy**

**Introduction and Purpose of the Guidance**

The purpose of this policy and procedure is for anyone who may encounter a woman who conceals the fact that she is pregnant, where this is a known previous concealed pregnancy or where a professional has a suspicion that a pregnancy is being concealed or denied.

The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and wellbeing of the foetus (unborn child) and the mother. There may be a number of reasons why a pregnancy is concealed or denied, for example:

A woman or girl may conceal their pregnancy if it occurred as the result of sexual abuse, either within or outside the family, due to her fear of the consequences of disclosing that abuse;

A pregnancy may be concealed in situations of domestic abuse, within a forced marriage or for a forced marriage to avoid shame on a family;

There is growing intelligence that suggests pregnant women are exploited for sham marriages and benefit fraud, likewise the unregulated nature of the surrogacy industry puts women and children at risk of exploitation and trafficking and may not therefore conceal their pregnancies due to control and coercion;

Due to stigma, shame or fear through cultural or family pressures, concealment may be a deliberate means of coping with the pregnancy or avoiding bringing shame on the family;

Fear of a child being removed where a woman has had a previous child removed, or asylum seekers and illegal immigrants who may be reluctant to inform the authorities that she is pregnant;

In some cases the woman may be truly unaware that she is pregnant until very late in the pregnancy, either due to age or learning disability if they do not understand why their body is changing;

There are links between denial of pregnancy and dissociative states brought about by trauma or loss; or denial stems from an expectant mother misusing drugs or alcohol which can harm the foetus or because of mental illness, such as schizophrenia.

While concealment and denial, by their very nature, limit the scope of professional help better outcomes can be achieved by coordinating an effective inter-agency approach. This approach begins when a concealment or denial of pregnancy is suspected or in some cases when the fact of the pregnancy (or birth) has been established. This will also apply to future pregnancies where it is known or suspected that a previous pregnancy was concealed or denied.

**Definition**

A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or any health professional; or when she tells another professional but conceals the fact that she is not accessing antenatal care; or when an expectant mother tells another person or persons and they conceal the fact from all health agencies.

A denied pregnancy is when an expectant mother is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases an expectant mother may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005).

For the purpose of this protocol any reference to an expectant mother includes females of childbearing capacity (including under 18's). A pregnancy will not be considered to be concealed or denied for the purpose of this protocol until it is confirmed to be at least 24 weeks; (in some organisations late booking may be considered earlier than this and Pan Lancashire pre-birth protocol may be considered at 16 weeks where there are significant safeguarding concerns). However by the very nature of concealment or denial it is not possible for anyone suspecting an expectant mother is concealing or denying a pregnancy to be certain of the stage the pregnancy is at.

**Evidence from Research and Serious Case Review**

Research into concealment and denial of pregnancy is relatively recent, in the last 40 years, and this work has attempted to understand the characteristics of women who conceal or deny their pregnancy. Research has also been carried out to explore links between concealed pregnancy and infanticide (killing of a child in the first year of life). Local Safeguarding Children Boards have conducted reviews of cases where concealment or denial of pregnancy has been identified as a factor in the death or serious injury of a child. The issue of concealment and denial of pregnancy, and infanticide/filicide (the killing of a child by a parent) can be evidenced throughout human history.

A summary of thirty-five major child death inquiries (Reder P, 1993) highlighted evidence of considerable ambivalence or rejection of some of those pregnancies and a significant number with little or no antenatal care. A follow-up study (Reder P. D., 1999) also identified a small sub-group of fatality cases where mothers did not acknowledge that they were pregnant and failed to present for any antenatal care and the babies were born in secret.

Several studies (Earl, 2000); (Friedman S. M., 2005); (Vallone, 2003) highlight a well-established link between neonaticide - killing of a child by a parent in the first 24 hours following birth - and concealed pregnancy. A review of 40 Serious Case Reviews (DoH, 2002) identified one death was significant to concealment of pregnancy.

A number of studies have attempted to identify the frequency of concealment or denial of pregnancy (Nirmal, 2006); (Wessel, 2002).

They suggest concealment might occur in about 1:2500 cases (0.04%). A study by (Friedman S. H., 2007) showed a higher proportion with 0.26% of all pregnancies in their sample (approx. 31,000) to be concealed or denied. The characteristics of those in this study showed that 50% of those concealing the pregnancy and 59% of those denying the pregnancy were aged between 18 and 29 years. Only 40% of those concealing and 23% of those in denial of their pregnancy were under 18 years of age.

A recent study in France into the rate of neonaticide by looking back at judicial data (court cases and inquests) concluded that the rate was 2.1 per 100,000 births, a much higher rate that the official mortality statistics suggested. All of the pregnancies identified in the study were concealed but none were completely denied by the woman (no awareness of being pregnant). The characteristics of the women in the study were explored and over half of them lived with the child's father, and 13 of the 17 women identified were classed as professionally active with a status identical to that of the general population. The authors concluded that neonaticide appeared as a solution to an unwanted pregnancy that risked a family scandal or loss of a partner or lifestyle. (Tursz and Cook, 2010)

The majority of religious faiths traditionally expect pregnancy to follow after marriage. Dependent upon the culture and religious observance, a pregnancy outside of marriage may have serious consequences for the women involved. This can create a significant pressure on an expectant mother to seek to conceal a pregnancy or for the psychological conditions to be present where a pregnancy is denied. In some local and national cases collusion between family and partners has occurred to facilitate and encourage concealment of the pregnancy from those outside of the family or wider culture/community. Some pregnant women, or their partners, who abuse drugs and /or alcohol may actively avoid seeking medical help during pregnancy for fear that the consequences of increased attention from statutory agencies can result in the removal of their child.

**Implications of a Concealed or Denied Pregnancy**

The implications of concealment and denial of pregnancy are wide-ranging. Concealment and denial can lead to a fatal outcome, regardless of the mother's intention.

Lack of antenatal care can mean that potential risks to mother and child may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given; such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy e.g. some epilepsy medication. NICE guidance published in October 2017 makes recommendations about practice in relation to children and young people under 18, including unborn babies.

Underlying medical conditions and obstetric problems will not be revealed if antenatal care is not sought. An unassisted delivery can be very dangerous for both mother and baby, due to complications that can occur during labour and the delivery. A midwife should be present at birth, whether in hospital or if giving birth at home.

**Good practice in antenatal care**

Midwives and GPs should care for women with an uncomplicated pregnancy, providing continuous care throughout. Obstetricians and specialist teams should be brought in where necessary;

In the first contact with a health professional, an expectant mother should be given information on folic acid supplements; food hygiene and avoiding food-acquired infections; lifestyle choices such as smoking cessation or drug use; and the risks and benefits of antenatal screening;

The booking appointment with a midwife ideally should be around 10 weeks. This appointment should help the expectant mother plan the pregnancy, offer some initial tests and take measurements to help determine any specific risks for the pregnancy. The expectant mother should be given advice on nutritional supplements and benefits;

Give information that is easily understood by all women, including those with additional needs, learning difficulties or where English is not their first language. Ensure the information is clear, consistent and backed up by current evidence;

Remember to give an expectant mother enough time to make decisions and respect her decisions even if they are contrary to your own views;

Women should feel able to disclose problems or discuss sensitive issues with you. Be alert to the symptoms and signs of domestic violence and abuse.

Adapted from Antenatal care: Routine care for the healthy pregnant woman, NICE, 2008 (NICE update due June 2020)

An implication of concealed or denied pregnancy could be a lack of willingness or ability to consider the baby's health needs, or lack of emotional bond with the child following birth. It may indicate that the mother has immature coping styles or is simply unprepared for the challenges of looking after a new baby. In a case of a denied pregnancy, the effects of going into labour and giving birth can be traumatic.

Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently. There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community; or because revealing the identity of the child's father may have consequences for the parents and the child.

**Where Suspicion Arises**

This section outlines actions to be taken when a concealed or denied pregnancy is suspected (see Section 2, Definition). If a pregnancy is suspected of being concealed or denied, the expectant mother should be strongly encouraged to go to her GP or direct to midwife to access ante-natal care. If the expectant mother accesses her GP, the GP practice will help her register with midwifery services for ultrasound scanning and advice about pregnancy and birth.

Professionals must balance the need to conserve confidentiality and the potential concern for the unborn child and the mother's health and wellbeing. Where any professional has concerns about concealment or denial of pregnancy, they should contact any other agencies known to have involvement with the expectant mother so that a fuller assessment of the available information and observations can be made.

Where there is strong suspicion of a concealed or denied pregnancy, it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the pregnant woman will override her right to confidentiality. A referral should be made to Children's Social Care about the unborn child - see Making Referrals to Children's Social Care Procedure and Pan Lancashire Pre Birth Protocol. A referral to Adult Social Care may be required if the mother has care and support needs. If the expectant mother is under 18 years, consideration will be given to whether she is a Child in Need. Where the mother is, or may have been at the time of conception, under the age of 18, professionals should follow the processes outlined in Sexually Active Young People Under the Age of 18 Procedure. In addition, if she is less than 16 years then a criminal offence may have been committed and this needs to be investigated.

The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the unborn young person or newborn baby.

The reasons will not be known until there has been a multi-agency assessment. If there is a denial of pregnancy, consideration must be given at the earliest opportunity to a referral to enable the expectant mother to access appropriate mental health services for an assessment. Advice can be sought from the designated or named professional or from Children's Social Care.

**Legal considerations about concealment and denial of pregnancy:**

United Kingdom law does not legislate for the rights of unborn children and therefore a foetus is not a legal entity and has no separate rights from its mother. This should not prevent plans for the protection of the unborn child being made and put into place to safeguard the baby from harm both during pregnancy and after the birth;

In certain instances legal action may be available to protect the health of a pregnant woman, and therefore the unborn child, where there is a concern about the ability to make an informed decision about proposed medical treatment, including obstetric treatment. The Mental Capacity Act 2005 states that person must be assumed to have capacity unless it is proven that she does not. A person is not to be treated as unable to make a decision because they make an unwise decision. It may be that a pregnant woman denying her pregnancy is suffering from a mental illness and this is considered an impairment of mind or brain, as stated in the act, but in most cases of concealed and denied pregnancy this is unlikely to be the case;

There are no legal means for a local authority to assume Parental Responsibility over an unborn baby. Where the mother is a child and subject to a legal order, this does not confer any rights over her unborn young person or give the local authority any power to override the wishes of a pregnant young person in relation to medical help.

**When a Concealed or Denied Pregnancy is Revealed**

This section outlines actions to be taken when a concealed or denied pregnancy is revealed. Midwifery services will be the primary agency involved with an expectant mother after the concealment is revealed, late in pregnancy or at the time of birth. However it could be one of many agencies or individuals that an expectant mother discloses to or in whose presence the labour commences. It is vital that all information about the concealment or denial is recorded and shared with relevant agencies to ensure the significance is not lost and risks can be fully assessed and managed.

Where a pregnancy is revealed to be denied and concealed it is vital the circumstances in each case are explored fully with the expectant mother and appropriate support and guidance offered to her. It is important to understand the reasons why the pregnancy has been denied or concealed.

When risks are identified as a results of a concealed on denied pregnancy then appropriate referrals should be made to relevant agencies for example Mental Health services or Children Social Care (please refer to Multi-Agency Pre-Birth Protocol).

**Educational Settings Including Early Help Services**

In many instances staff in these settings may be the professionals who know a young person best.

There are several signs to look out for that may give rise to suspicion of concealed pregnancy:

Increased weight or attempts to lose weight;

Wearing uncharacteristically baggy clothing;

Concerns expressed by friends;

Repeated rumours around school or college;

Uncharacteristically withdrawn or moody behaviour;

Missing from education, child sex exploitation and missing from home.

Staff working in educational settings, including Early Help, should try to encourage the student to discuss her situation, through normal pastoral support systems, as they would any other sensitive issue. Every effort should be made by the professional suspecting a pregnancy to encourage the young person to obtain medical advice. However where they still face total denial or non-engagement further action should be taken. It may be appropriate to involve the assistance of the Designated Lead Person for Safeguarding in addressing these concerns.

Consideration should be given to the balance of need to preserve confidentiality and the potential concern for the unborn child and the mother's health and wellbeing. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained.

Staff may often feel the matter can be resolved through discussion with the parent of the young person. However this will need to be a matter of professional judgment and will be clearly depend on individual circumstances including relationships with parents. It may be felt that the young person will not admit to her pregnancy because she has genuine fear about her parent's reaction, or there may be other aspects about the home circumstances that give rise to concern, such as domestic or sexual abuse, honour based abuse, forced marriage and FGM. If this is the case then a referral to Children's Social Care should be made without speaking to the parents first - see Making Referrals to Children's Social Care Procedure.

If education staff engage with parents they need to bear in mind the possibility of the parent's collusion with the concealment. Whatever action is taken, whether informing the parents or involving another agency, the young person should be appropriately informed, unless there is a genuine concern that in so doing she may attempt to harm herself or the unborn baby.

If there is a lack of progress in resolving the matter in the setting or escalating concerns that a young person may be concealing or denying she is pregnant, there must be a referral to Children's Social Care. Where there are significant concerns regarding the girl's family background or home circumstances, such as a history of missing from home, risk of CSE, abuse or neglect, a referral should be made immediately. As with any referral to Children's Social Care, the parents and young person should be informed, unless in doing so there could be significant concern for her welfare or that of her unborn child.

**Health Professionals**

The local commissioners of health services are responsible for ensuring all its commissioned providers of health care fulfil their statutory responsibilities for safeguarding children.

The health professionals whom may be involved include:

Paediatrician;

Health Visitors;

School nurses;

Sexual Health and GUM services;

General Practitioners and Practice nurses;

Midwifes and Obstetricians/Gynaecologists;

Mental Health Nurses;

Drug and Alcohol workers;

Learning Disability workers;

Psychologists and Psychiatrists;

SUDC (Sudden or Unexpected Death in Childhood) Nurses;

Commissioned termination of pregnancy services.

(This is not an exhaustive list)

If a health professional suspects or identifies a concealed or denied pregnancy and there are significant concerns for the welfare of the unborn baby, (s)he must refer to Children's Social Care - see Making Referrals to Children's Social Care Procedure / pre-birth protocol - and inform all the health professionals, including the General Practitioner, involved in the care of the woman.

All health professionals should give consideration to the need to make or initiate a referral for a mental health assessment at any stage of concern regarding a suspected (or proven) concealed or denied pregnancy.

Accident and Emergency staff or those in Radiology departments need to routinely ask women of childbearing age whether they might be pregnant. If suspicions are raised that a pregnancy may be being concealed, these staff should follow safeguarding procedures (Section 5, Where Suspicion Arises) or revealed (Section 6, When a Concealed or Denied Pregnancy is Revealed).

Health professionals who provide help and support to promote children's or women's health and development should be aware of the risk indicators and how to act on their concerns if they believe a woman may be concealing or denying a pregnancy.

GP practices should record the concealed pregnancy on both the mothers and baby's notes as this information could be of relevance in future safeguarding decision making.

**Midwives and Midwifery Service**

If an appointment for antenatal care is made late (beyond 24 weeks), the reason for this must be explored. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby, a referral to Children's Social Care must be made - see Making Referrals to Children's Social Care Procedure / pre-birth protocol. The expectant mother should be informed that the referral has been made, the only exception being if there are significant concerns for her safety or that of the unborn child.

If an expectant mother arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, then an urgent referral must be made to Children Social Care. If this is in an evening, weekend or over a public holiday then the Children Social Care Emergency Duty Team must be informed.

If the baby has been harmed in any way or there is a suspicion of harm, or the child is abandoned by the mother, then the Police must be informed immediately and a referral made to Children's Social Care.

Midwives should ensure information regarding the concealed pregnancy is placed on the child's, as well as the mother's, health records. Following an unassisted delivery or a concealed/denied pregnancy, midwives need to be alert to the level of engagement shown by the mother, and her partner/extended family if observed, and of receptiveness to future contact with health professionals. In addition midwives must be observant of the level of attachment behaviour demonstrated in the postnatal period.

Neither baby nor the mother should be discharged until they have had full assessment of their needs, including identification of risks and a multi-agency discharge planning meeting held. A discharge summary from maternity services to the relevant GP must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks).

**Children's Social Care**

Children's Social Care / Emergency Duty Team may receive a referral from any source, which suggests a pregnancy is being concealed or denied. Safeguarding processes must be implemented and consideration of an assessment should be made.

This would ordinarily be done by voluntary agreement with the mother, although where the mother's consent is not freely given, consideration should be given to whether there are grounds for seeking an Emergency Protection Order to ensure the baby remains in hospital until a the discharge plan is agreed. Alternatively the assistance of the Police - via Police Protection - may be sought to prevent the child from being removed from the hospital.

If the baby is born at home the midwife or ambulance service (which ever professional is present), should ensure the baby is admitted to hospital even if the mother herself declines her own admission.

Where the expectant mother is under the age of 18, initial approaches should be made confidentially to the young person to discuss concerns regarding the potential concealed or denied pregnancy and unborn child. She should be provided with the opportunity to confirm the pregnancy by undertaking appropriate tests or to make plans for the baby. There may be significant reasons why a young person may be concealing a pregnancy from her family and a professional should consider speaking to her without her parent's knowledge in the first instance.

Where there are clear reasons for suspecting pregnancy in the face of continuing denial or concealment, the professionals will need to continue to assess the situation with a focus on the needs /welfare of woman. It must not be forgotten that where the mother is under 18, she may also be considered a Child in Need or Child in Need or Protection. Such a situation will require very sensitive handling.

Regardless of the age of the expectant mother where there are additional concerns (i.e. as well as the suspected concealed or denied pregnancy) where risk factors are present, including ongoing/previous child protection concerns Social Care must undertake an appropriate safeguarding assessment.

If an expected mother has arrived at hospital either in labour or following an unassisted birth when a pregnancy has been concealed or denied, an Assessment of risks is made and Children Social Care are to undertake an appropriate safeguarding assessment.

Where a baby has been harmed, has died or has been abandoned a Section 47 enquiry must be completed in collaboration with the Police and the Pan Lancashire SUDC (Sudden or Unexpected Death in Childhood) Protocol initiated Management of Sudden Unexpected Deaths in Childhood (SUDC).

In undertaking an assessment the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child. These factors, along with the other elements of the Continuum of Need Risk Sensible Framework for Multi Agency Partners and Assessment Framework will be key in determining risk.

Accessing psychological services in concealment and denial of pregnancy may be appropriate and consideration should be given to referring an expectant mother for psychological assessment. There could be a number of issues for the woman, which would benefit from psychological intervention. A psychiatric assessment might be required in some circumstances, such as where it is thought she poses a risk to herself or others or in cases where a pregnancy is denied.

The pathway for psychological or psychiatric assessment, either before or after pregnancy, is the same. A referral should be made using the single point of entry to mental health services and the referral letter copied to the woman's GP. The referral should make clear any issues of concern for the woman's mental health and issues of capacity.

**Police**

The Police will be notified of any child protection concerns received by Children's Social Care where concealment or denial of pregnancy is an issue. A police representative will be invited to attend the multi-agency Strategy Meeting and consider the circumstances and to decide whether a joint Child Protection investigation should be carried out.

Factors to consider will be the age of the expectant mother who is suspected or known to be pregnant, and the circumstances in which she is living to consider whether she is a victim or potential victim of criminal offences. In all cases where a child has been harmed, been abandoned, died or expected to die it will be incumbent on the Police and Children's Social Care to work together to investigate the circumstances. This will involve the Pan Lancashire SUDC team in the event of a child death or where the prognosis is poor. Where it is suspected that neonaticide or infanticide has occurred then the Police will be the primary investigating agency.

**Other LSCB Member Agencies (including the Voluntary Sector).**

All professionals or volunteers in statutory or voluntary agencies who provide services to women of child bearing age should be aware of the issue of concealed or denied pregnancy and follow this procedure when a suspicion arises.

All referrals will be made to the Children's Social Care initially as a referral on an unborn child. Where the expectant mother is under 18 years of age she will be considered as a Child in Need and assessed accordingly.

**Dangerous or Out of Control Pets**

**Introduction and Definition**

The benefits of owning pets are well established. Living in a pet owing household can have physical and emotional benefits for children as well as teaching them about responsibility and caring for living creatures. However, in recent years a number of children of different ages have been seriously injured or have died from attacks by dogs, and it is important therefore that professionals working with children and families are aware of the issues around dangerous dogs and the risks they can pose to children and young people.

The aim of this chapter is to help practitioners to understand how to assess any risks which dogs in then household might pose to children and take action as necessary to protect children from serious injuries which can be inflicted by pets that are prohibited, dangerous or badly looked after or mistreated by their owners. It also provides advice for practitioners to enable them to undertake home visits more safely.

The guidance covers the following:

How to routinely ask questions about dogs in the household or in regular contact with children and young people and how to assess any associated risks;

The action that should be taken if a child is living in a household with a prohibited or dangerous dog; and

The information that should be gathered when any child is injured by a pet and the issues to be considered when making a referral in line with the Making a Referral to Children's Social Care Procedure.

The abuse of animals can be part of a constellation of intra-familial abuse, which can include maltreatment of children and domestic violence and 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 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.

Note that the chapter refers to pets throughout in order to promote the need for practitioners to consider the risks presented by any animal, however specific legislation only applies to dogs.

**Legislation Relating to Dangerous Dogs and Other Pets**

The Dangerous Dogs Act (1991) provides detailed information about the legislation covering certain types of dogs, sets out the responsibilities of the owners and described the actions that can be taken to remove and/or control dogs:

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 immediately;

Any dog can be 'dangerous' (as defined by the Act) if it has already been known to inflict or threaten injury;

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 to children and potential consequences.

Lancashire Constabulary have provided the additional guidance included within Section 6, Further Information which provides more detailed guidance for identifying dangerous dogs.

Part 7. of the Anti-social Behaviour, Crime and Policing Act 2014 strengthens powers to tackle irresponsible dog ownership by extending the offence of owning or being in charge of a dog that is dangerously out of control in a public place to also cover private places. It also provides that a dog attack on an assistance dog constitutes an aggravated offence.

Part 7. also ensures that the courts can take account of the character of the owner of the dog, as well as of the dog itself, when assessing whether a dog should be destroyed on the grounds that it is a risk to the public.

The Home Office Crime Classification 8/21 is amended to: "Owner or person in charge allowing a dog to be dangerously out of control in any place in England or Wales (whether or not in a public place) injuring any person or assistance dog." Section 3 (1) Dangerous Dogs Act 1991 as amended by Section 106 Anti-Social Behaviour Crime and Policing Act 2014.

The Dangerous Wild Animals Act 1976 requires keepers of dangerous or wild animals to hold a licence. These are issued by unitary and district authorities who may be able to advise practitioners who encounter unusual pets in the course of home visits.

**Assessing Risks to Children and Young People**

When a practitioner from any agency undertakes a home visit and there are both children and pets in the household, the practitioner should routinely consider whether the presence of the pets presents any kind of risk to the welfare of the child/ren. This should involve a discussion with the parents or the pet owner about the dog’s behaviour. This is particularly important when there is a new baby in the household. The pet owner should be asked whether the dog’s behaviour has changed since the baby was brought home. This assessment of risk should be repeated when the baby begins to become mobile.

There will be times when even the most well cared for pet, behaves in a way that had not been expected. The care, control and context of a pet's environment will impact on the pet’s behaviour and the potential risks it may pose. Research indicates that neutered or spayed pets are less likely to be territorial and aggressive towards other dogs and people. Pets that are kept and/or bred for the purpose of fighting, defending or threatening others are likely to present more risks than genuine pets.

All children are potentially vulnerable from an attack by a pet but very young children are likely to be at greatest risk. A young child will be unaware of the potential dangers they could face and will be less able to protect themselves. Small children are of a size that leaves especially vulnerable parts of their body exposed. The question should be asked: ‘is the pet left alone with the child?’ This applies even if the child is in a cot, bed or seat of some kind.

See also Animal Welfare for guidance from the RSPCA on assessing the whether a dog’s welfare needs are being met.

If it is the professional judgement of the practitioner that a pet is prohibited or presents a risk to a child, the Police or Children’s Social Care should be contacted immediately.

National animal welfare charities provide a wide array of useful advice and information about looking after pets and ensuring the safety of children. The general advice that is provided from all animal welfare charities includes:

Do not leave babies and young children unattended around pets;

Do not leave doors open to children’s rooms allowing pets access to sleep areas;

Ensure children are not sleeping in areas of the house where the pets may usually also sleep;

Do not ignore pets when they show aggression – always separate pets away from children; and

Teach children not to disturb pets when they are sleeping, eating, caring for their offspring or when pets are ill or injured.

**Protection and Action to be Taken**

Any agency that becomes aware of a dog that could be prohibited or considered dangerous, should collect the following information:

The dog's name and breed and/or description;

Information about the owner;

The reason for keeping the dog and information about other family members, particularly young children.

Where there is a report of a child having been injured by any pet (or exposed to the risk of injury) a referral to Children’s Social Care should be considered. In deciding whether or not to make a referral, consideration should be given to:

The nature of the injuries;

The circumstances of the attack / incident;

Whether the parents or dog owner sought medical advice;

Whether the dog has previously shown any aggression; and

What action the pet owner has taken to prevent a recurrence of any attack.

Remember, if a practitioner has reason to believe that a dog in the household is prohibited or presents a risk to a child, the Police or Children’s Services should be contacted immediately. Other considerations before making a referral should be:

The injured child is under two years of age;

The child is under five years of age and the injuries have required medical treatment;

The child is over five years and under 18 and has been injured more than once by the same pet;

The child/young person is under 18 years of age, the 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.

A referral should also be made where a prohibited and/or dangerous dog is reported and/or treated, and is believed to be living with and/or frequently associated with children.

Some referrals might be logged 'for information only' by the agencies, for example if it is clearly established that no significant or continued risk is likely to the child, or other children (for example, if the pet – which was the only dog in the household has already been 'put down' or removed to another house where no children are present).

Some referrals might prompt 'information leaflets' on Pets and Safe Care of Children to be issued for example, if the incident or injury was clearly minor, if the child was older or if the family have clearly shown themselves to be responsible pet owners. See - Parent Tips - Keeping Babies and Children Safe Around Dogs in the Home (Institute of Health Visiting) and The Blue Cross Be Safe with Dogs Leaflet - Guidance for Families.

In more serious cases a Strategy Discussion and joint Section 47 investigation should lead to further discussions with other agencies and home visits to complete assessments and to inform judgements on parenting and the care and control of the pet(s).

Advice might be sought from a veterinary professional to help determine the likely nature or level of risk presented by the pet(s). As with all other assessments 'the welfare of the child is paramount.'

**Practitioner Safety**

The following advice is adapted from East Riding LSCB and Lancashire Constabulary:

Animals can sense fear so avoid eye contact and be confident;

Where a sense of fear is not avoidable, ask the pet owner to move the pet(s) to another room or conduct the discussions of the home visit in another room;

In subsequent visits to the service user, write in advance to the pet owner to ensure that the pet is in a different room or secure in its cage etc.

Do not approach or stroke pets;

Look out for signs of aggression in the pet and confidently request the owner to remove the pet from the room.

**Animal Welfare**

The RSPCA offer the following 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."

**Disabilities and Learning Difficulties**

**Introduction**

It is a fundamental principle that children with disabilities and learning difficulties have the same right as children without disabilities and learning difficulties to be protected from harm and abuse and that standard procedures should be followed for Referrals, Single Assessment and, when appropriate, Strategy Discussions/Meetings (local processes for including disability and learning difficulty specialists in the safeguarding processes will vary). However in order to ensure that the welfare of children with disabilities is safeguarded and promoted, it needs to be recognised that additional action is required in particular assessing and addressing their equality needs in line with the Equality Act duties. This is because children with disabilities and learning difficulties 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.

Children with disabilities and learning difficulties are likely to have poorer outcomes across a range of indicators including low educational attainment, poorer access to health services, poorer health outcomes and more difficult transitions to adulthood. They are more likely to suffer family break up and are significantly over-represented in the populations of looked after children and young offenders.

Where children with disabilities and learning difficulties 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.

Families with children with disabilities are more likely to experience poverty and children with special educational needs are more likely to be excluded from school, (70% of all permanent exclusions are for students with SEND).

Research evidence suggests that children with disabilities and learning difficulties are at increased risk of abuse and neglect, and that the presence of multiple disabilities and difficulties appears to increase the risk of both abuse and neglect, yet they are underrepresented in safeguarding systems. Children with disabilities and learning difficulties can be abused and neglected in ways that other children cannot and the early indicators suggestive of abuse and neglect can be more complicated than for children with disabilities. Research evidence also indicates that the indicators of abuse and neglect for children with disabilities and learning difficulties can sometimes be confused with their conditions leading to delays in identifying abuse or neglect.

Whilst the practice guidance does not identify specific groups of children with disabilities or learning difficulties, 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 children with disabilities and learning difficulties including recognising that all children communicate preferences if asked in the right way by those who understand their needs and have the skills to listen to them. Research evidence suggests that overreliance on the preferences communicated by parents/carers rather than through communicating with the child or observations can make it more difficult to identify and assess whether a child is suffering from abuse or neglect.

Various definitions of disability and learning are used across agencies and professionals. Agreement between specialists on diagnosing a condition and it’s of level of severity can make it more difficult to understand and provide for the additional needs the child may have. Whatever definition of 'disability' or ‘learning difficulty’ is used, the key issue is not what the definition is but the impact of abuse or neglect on a child's health and development, and consideration of how best to safeguard and promote the child's welfare. The definition of abuse and neglect is universal.

**Practice Guidance for Professionals**

The reasons why children with disabilities and difficulties are more vulnerable to abuse are summarised below:

Many children with disabilities and learning difficulties are at an increased likelihood of being socially isolated with fewer outside contacts than children without disabilities and learning difficulties;

Their dependency on parents and carers for practical assistance in daily living including intimate personal care and medical/medicine management increases their risk of exposure to abusive behaviour;

They have an impaired capacity to resist or avoid abuse;

They may have impairments in their cognitive ability to understand the abuse or neglect;

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 children with disabilities and learning difficulties are not only vulnerable to the same factors that exist for all children living away from home but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical needs.

Where there are safeguarding concerns about a children with disabilities and learning difficulty, there is a need for greater awareness of the possible indicators of abuse and/or neglect as the situation is often more complex. It is crucial that the disability or learning difficulty is not allowed to mask or deter the need for an appropriate investigation of child protection concerns. Best practice recommends that specialists who work with children with disabilities and learning difficulties seek advice from practitioners that regularly assess abuse and neglect; safeguarding specialists and social workers in turn should seek advice from specialists in children’s disabilities and learning difficulties (across the whole range of specialists that would be required to meet the child’s needs) when assessing abuse and neglect.

The following are some indicators of possible abuse or neglect:

Bruises, injuries or pressure sores in a site that might not be of concern on an ambulant child, but might be a concern on a non-mobile child or child with restricted ability to move;

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, over feeding/over medication;

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;

Patterns of missed appointments with medical and social care specialists (including consistently refusing assistance or parents/carers not being available to professionals) leaving the child with unaddressed needs;

Parents showing hostility towards professionals or withdrawing their child from services when challenged with indicators of unmet need.

These indicators are not exhaustive and as each child’s disability and learning difficulty will vary by severity requiring sometimes a whole range of specialists to diagnose and provide advice on management making it difficult to determine levels of unmet need. The definition for abuse or neglect does not vary from child to child and a multitude of persistent unmet needs is likely to indicate a child is suffering or likely to suffer significant harm.

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 or neglect is taking or has taken place, or seeing it as being attributable to the stress and difficulties of caring for a child with disabilities and learning difficulties;

A lack of knowledge about the impact of disability and learning difficulties 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;

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 who are likely to receive initial contacts and/or referrals concerning children with disabilities should have received appropriate training to equip them with the knowledge and awareness to assess the risk of harm to the child and know what action to take. Children’s Services will have access to specialist teams in social care and education that routinely provide services to children with disabilities and learning difficulties and practitioners screening and assessing referrals should seek their advice in making decisions. Health specialists in the Multi-Agency Safeguarding Hubs(MASH) will have good knowledge and contacts with the range of specialists in community and in hospital settings that can also provide advice on disabilities and learning difficulties to understand the specific needs of a child.

Assessment should be undertaken by professionals who are both experienced and competent in child protection work, with additional input from those professionals who have knowledge and expertise of working with children with disabilities and learning difficulties (education and health). Where assessing a teenage child there may be an additional need to include adult services across health and social care into the assessment, planning and review processes.

A good question when assessing a child with disabilities is: Would I consider that option if the child did not have a disability or learning difficulty?

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 child with disabilities:

What is the disability, special need or impairment that affects the child? Ask for a description of the disability or impairment;

Make sure that you spell the description of an impairment correctly;

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?

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, consideration should be given to appoint a support worker to consider any complex issues arising from the disability. If a facilitator or interpreter is required, he or she should be involved when planning the investigation. See also Use of Interpreters, Signers or Others with Communication Skills Procedure.

Where an interview with the child with disabilities or learning difficulty is required, 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 child with disabilities and the family as well as with each other as there are likely to a greater number of professionals involved.

Professionals should be advised to refer to the appendices of the government's guidance for a list of helpful resources and more detailed assessment tools and research literature.

In assessing whether a child with disabilities and learning difficulties is being abused or neglected, the Single Assessment must be fully informed by an Equalities Assessment. All public bodies (and services provided through public service commissions) have duties under the Equality Act 2010 and organisations will have appointed an Equalities Lead who can advise on completing equality impact assessments. For some children they may have a number of protected characteristics (see Diversity Procedure) and each must be equally assessed. Working Together guidance is clear that the rights of the child are paramount and so where a parent/carer equally has diversity needs, the child’s rights must take priority to ensure they are safeguarded effectively.

Understanding and responding to abuse and neglect in children with disabilities and learning difficulties can be difficult for the different reasons outlined above. Practitioners should seek regular support and supervision to assist them in their roles, including specialist safeguarding supervision. Addressing the needs of a child with disabilities and learning difficulties is not a single agency response and there must be frequent and purposeful multi-agency working across planning processes like Early Help Assessment, EHCP, CiN, CP, LAC, Leaving Care etc. Multi-agency working will also involve very different disciplines (in health, social care, education, child or adult services, legal services in different providers, commissioners and providers) that talk different professional languages and supervision and support should also be used across the different disciplines to ensure misunderstandings do not arise and there are no gaps in the child’s unmet needs.

**Diversity**

**Introduction**

The population of the regions covered by the Consortium is multi-cultural. In order to make sensitive and informed professional judgements about a child's needs and parents' capacity to respond to their child's needs, it is important that professionals are sensitive to differing family patterns and lifestyles and to child rearing patterns that vary across different racial, ethnic and cultural groups.

Professionals should also be aware of the broader social factors that serve to discriminate against black and minority ethnic people. The assessment process should always include consideration of the way religious beliefs and cultural traditions in different racial, ethnic and cultural groups influence their values, attitudes and behaviour and the way in which family and community life is structured and organised.

Professionals should guard against myths and stereotypes, both positive and negative, but anxiety about being accused of racist practice should not prevent the necessary action being taken to safeguard a child.

**Principles**

The Local Safeguarding Children Board (LSCB) and its agencies are committed to promoting equal opportunities and valuing diversity in all its functions, roles and services it provides. The regions covered by the Consortium are multi-racial, multi-religious, multi-language and multi-cultural. All our policies, procedures, practice and services should positively acknowledge, reflect and respect this fact.

This means the LSCB and its agencies will:

Work to achieve social justice and inclusion that enables all children and their families to have equality of opportunity;

Oppose and prevent discrimination, victimisation or harassment against any of the eleven characteristics of equality (nine characteristics required by the Equality Act 2010 and two adopted by local partnerships to reflect local needs);

Treat all citizens fairly and with respect;

Recognise the rights of individuals to participate fully in the social and economic life.

**Nine Strands of Diversity**

There are nine characteristics to this Equality Policy which the LSCB’s and its agencies are committed to adhere to:

Age;

Disability;

Gender Re-assignment;

Marriage & Civil Partnerships;

Pregnancy & Maternity;

Race;

Religion or Belief;

Sex/Gender;

Sexual Orientation;

Section 149 of the Equality Act (2010) requires the following provisions to be made by agencies (public sector bodies) for their employees and service users:

Eliminate any discrimination, victimisation or harassment;

Advance equality of opportunity and foster good relations between persons who share a protected characteristic and persons who do not share it;

Remove or minimise disadvantages suffered by persons who share a protected characteristic that are connected to that characteristic;

Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low

Foster good relations between persons who share a relevant protected characteristic and persons who do not share to tackle prejudice and promote understanding.

Paragraph 1.14 of Working Together to Safeguard Children (2015) outlines two key principles that underpin effective safeguarding arrangements and services: that safeguarding is everyone’s responsibility; and the need for agencies to have a child-centred approach in their safeguarding work. The guidance outlines in paragraph 1.22 that to be child-centred requires agencies in the public sector to fulfil their duties under the 2010 Equality Act (in addition to their duties under the Children Acts and Human Rights Act). Paragraph 1.22 further states that agencies have a duty to eliminate discrimination and promote equality of opportunity in the identification, assessment and service provision functions within safeguarding work.

The following six competencies have been adapted from work the Pan-London LSCBs have undertaken that can be used as a framework for effective safeguarding practice:

Child Development – knowing how a healthy child presents or behaves so that signs of distress and impaired development can be identified as early as possible (Level 1 of the LSCB’s Continuum of Need and Response Framework);

Listening to the child and taking what they say seriously, including communication with the child (and family) in their preferred language;

Good holistic assessments that address all the principles and the three assessment domains in the LSCB’s Assessment Protocol, and take account of the Borough’s Risk Sensible Model;

Awareness of the local and statutory protected characteristics so that in undertaking an assessment and providing services, due regard is given to what is prohibited, and what requires promotion, under the Equality Act (2010) and Human Rights Act (1998);

Knowing, learning about or seeking expert advice on a particular protected characteristic by which the child and family lives their daily lives; and

Knowing about local services (depending on the type of protected characteristic maybe even regional or national services) that are available to provide relevant input into prevention, support and rehabilitation services for the child (and their family).

Agencies must have essential safeguards in place to promote the welfare of children, particularly those vulnerable due to their protected characteristics not being effectively assessed and met:

Children should feel valued and respected with their self-esteem promoted;

Agencies should recognise that needs within each protected characteristic will not be uniform and attention needs to be given to the specific needs of the child and family;

Staff should recognise the importance of ascertaining the wishes and feelings of children and their families including their preferred means of communication and language interpretation needs;

That staff are trained and have access to resources to help them identify and assess vulnerabilities that can arise from not meeting the needs relating to protected characteristics of a child and/or their family;

Providing access to services for specific groups of children that can promote their different needs;

That agencies should fully understand the communities they serve and the needs and challenges in terms of safeguarding that these communities may have and how services will have to be delivered to promote welfare; and

Complaints and comments procedures are clear, effective, user-friendly and accessible.

**Institutional Racism**

Children from black and minority ethnic groups (and their parents) are likely to have experienced harassment, racial discrimination and institutional racism. Although racism can cause Significant Harm, it is not, in itself, a category of abuse. The experience of racism is likely to affect the responses of the child and family to assessment and Section 47 Enquiry processes. Failure to consider the effects of racism undermines efforts to protect children from other forms of Significant Harm.

The effects of racism differ for different communities and individuals and should not be assumed to be uniform. Attention should be given to the specific needs of children of mixed parentage and refugee children. In particular, the need for neutral, high-quality, gender-appropriate translation or interpretation services should be taken into account when working with children and families whose preferred language is not English.

All organisations working with children, including those operating in areas where black and minority ethnic communities are numerically small, should address institutional racism, defined in the Macpherson Inquiry Report (2000) on Stephen Lawrence as 'the collective failure by an organisation to provide an appropriate and professional service to people on account of their race, culture and/or religion’.

**Domestic Violence and Abuse**

**Introduction**

Domestic violence and abuse is a complex issue which affects every one of us and reaches every corner of our society. Domestic violence and abuse is a serious crime and should be treated as such. It does not recognise class, race, religion, gender, sexuality, culture or wealth and its effects on family life are devastating.

In the overwhelming majority of reported instances the abuser is male and the victim is female, although there are attacks by women on men and between two people of the same gender, whether current or ex partners or family members.

**Definition**

The Home Office Guidance Information for Local Areas on the Change to the Definition of Domestic Violence and Abuse (2013) states that the term ‘domestic violence and abuse’ should be used. The Government definition of domestic violence and abuse has been widened to include those aged 16-17 and the wording changed to reflect coercive control. (Note that this is not a legal definition.)

The new definition is:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality'. This can encompass, but is not limited to, the following types of 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 that is used to harm, punish, or frighten their victim.'

The definition Domestic Violence and Abuse includes Forced Marriage, Honour-Based Abuse and Female Genital Mutilation, and is clear that victims are not confined to one gender or ethnic group.

While the cross-government definition above applies to those aged 16 or above, ‘Adolescent to parent violence and abuse‘ (APVA) can involve children under 16 as well as over 16. See: Information guide: adolescent to parent violence and abuse (APVA) Home Office.

For more details of the national plans to tackle domestic violence and abuse see: Ending Violence against Women and Girls Strategy 2016 – 2020 March 2016. This is intended to set out a life course approach to ensure that all victims - and their families - have access to the right support at the right time to help them live free from violence and abuse.

**Impact on Children and Young People**

Prolonged and / or regular exposure to domestic violence and abuse can have a serious impact on a child's development and emotional wellbeing, despite the best efforts of the victim parent to protect the child. Domestic violence and abuse has an impact in a number of ways. It can pose a threat to an unborn child, because assaults on pregnant women frequently involve punches or kicks directed at the abdomen, risking injury to both mother and foetus. It can also lead to other possible risks, such as i.e. foetal death, low birth weight, early birth, infection etc.

Older children may also suffer blows during episodes of abuse. Children are likely to be greatly distressed by witnessing the physical and emotional suffering of a parent or other family member. Both the physical assaults and psychological abuse suffered by adult victims who experience domestic violence and abuse can have a potential impact on their ability to look after their children.

The negative impact of domestic violence and abuse is exacerbated when the abuse is combined with drink or drug misuse as this can increase the severity of the attacks. Children's exposure to parental conflict; even where abuse is not present, can lead to serious anxiety and distress among children, particularly when it is routed through them.

Children may suffer both directly and indirectly if they live in households where there is domestic violence and abuse. Domestic violence and abuse is likely to have a damaging effect on the health and development of children, and it will often be appropriate for such children to be regarded as a Child in Need. All those working with families and children should be alert to the frequent inter-relationship between domestic violence and abuse and the abuse and neglect of children.

When there is evidence of domestic violence and abuse, the implications for any children in the household should be considered, including the possibility that the children may themselves be subject to abuse or other harm. Conversely, where it is believed that a child is being abused, those involved with the child and family should be alert to the possibility of domestic violence and abuse within the family.

Domestic violence and abuse is a child protection issue. In relation to the impact of domestic violence and abuse on children, the amendment made in Section 120 of the Adoption and Children Act 2002 to the Children Act 1989 clarifies the meaning of "harm" in the Children Act, to make explicit that "harm" will include, for example, "impairment suffered from seeing or hearing the ill-treatment of another." This is now also specifically included in the definition of Emotional Abuse.

**Action to Safeguard Children**

The Police are often the first point of contact with families in which domestic violence and abuse takes place. When responding to incidents of violence, the Police should find out whether there are any children living in the household. They should see any children present in the house to assess their immediate safety. There should be arrangements in place between the Police and Children's Social Care to enable the Police to find out whether any such children are the subject of a Child Protection Plan.

The Police are already required to determine whether any court orders or injunctions are in force in respect of members of the household. The Police should make an assessment and, if they have specific concerns about the safety or welfare of a child, they should make a referral to Children's Social Care (see the Making a Referral to Children's Social Care). It is also important that there is clarity about whether the family is aware that a referral is to be made. Any response by Children's Social Care to such referrals should be discreet, in terms of making contact with victims in ways that will not further endanger them or their children. In some cases, a child may be in need of immediate protection. As indicated above, the amendment to the Children Act 1989 made in Section 120 of the Adoption and Children Act 2002 clarifies the meaning of 'harm' in the Children Act, to make explicit that 'harm' includes, for example, impairment suffered from seeing or hearing the ill-treatment of another.

Normally, one serious or several lesser incidents of domestic violence and abuse where there is a child in the household indicate that Children's Social Care should carry out a Single Assessment of the child and family, including consulting existing records. It is important to include in assessments agreed arrangements for contact between children and the non-resident parent. Children who are experiencing domestic violence and abuse may benefit from a range of support and services, and some may need safeguarding from Significant Harm. Often, supporting a non-violent parent is likely to be the most effective way of promoting the child's welfare. The Police and other agencies have defined powers in criminal and civil law that can be used to help those who are subject to domestic violence and abuse. Health visitors and midwives can play a key role in providing support, and need access to information shared by the Police and Children's Social Care. See the Information Sharing and Confidentiality Procedure.

There is an extensive range of services for women and children, delivered through refuge projects operated by Women's Aid, and Probation Service provision of Women's Safety Workers, for partners of male perpetrators of domestic violence and abuse, where they are on a domestic violence and abuse treatment programme (in custody or in the community). These services have a vital role in contributing to an inter-agency approach in child protection cases where domestic violence and abuse is an issue. There are a number of services available to everyone suffering domestic violence and abuse, links to some of these can be found in the local contacts domestic violence and abuse services, such as Blackpool Children's Independent Domestic Violence Advisers (CIDVA), Multi Agency Risk Assessment Conference (MARAC), Victim Support etc.

In responding to situations where domestic violence and abuse may be present, considerations include:

Ensure the perpetrator and victim are not sitting together when being asked these questions;

Ask direct questions about domestic violence and abuse;

Check whether domestic violence and abuse has occurred whenever child abuse is suspected, and consider the impact of this at all stages of assessment, Section 47 Enquiries and intervention;

Identify those who are responsible for domestic violence and abuse, in order that relevant family law or criminal justice responses may be made;

Take into account there may be continued or increased risk of domestic violence and abuse towards the abused parent and/or child after separation, especially in connection with post-separation child contact arrangements;

Provide non-abusing parents with full information about their legal rights, and about the extent and limits of statutory duties and powers;

Help victims and children to get protection from violence, by providing relevant practical and other assistance;

Support non-abusing parents in making safe choices for themselves and their children;

Work separately with each parent where domestic violence and abuse prevents non-abusing parents from speaking freely and participating without fear of retribution. This should always be done as victims will also be at risk if they speak freely about the abuse in front of the perpetrator.

**Roles of Agencies**

Professionals, carers or volunteers may be alerted to the possibility of domestic violence and abuse involving children in a number of different ways. The most important thing to do is not to ignore your concerns. Consult with your manager / Designated or Named Professional, Nurse / Designated Teacher. All professionals should undertake a CAADA DASH Risk Indicator Checklist with the non-abusing parent when domestic violence and abuse is an issue. This should also be completed for 16 - 17 year old and vulnerable adult victims and refer to MARAC if necessary. Vulnerable Adults should also be referred to Safeguarding Adults Team. See also Information Sharing and Confidentiality Procedure.

**Children's Social Care**

Children's Social Care has a responsibility to assist those who experience abuse through the provision of appropriate information, offering advice and support and signpost to other avenues of support. They have a statutory responsibility in respect of ensuring that children and young people are protected from harm. This responsibility is fulfilled by their undertaking an assessment of children's needs. Where there is domestic violence and abuse within a family where children are present, consideration should always be given to an assessment of the child's needs being undertaken.

**Education Services**

Schools and Education staff have an essential role in the recognition stage of work with Early Help and Children in Need, including those in need of protection. All schools and colleges should create and maintain a safe environment for children and young people and have sound policies and procedures for managing situations where there are child welfare concerns. Staff who have day-to-day contact with children have a crucial role to play in noticing indicators of possible abuse or neglect, including the possibility of domestic violence and abuse, which can affect a child. Education department staff and schools have a duty to assist Children's Social Care by providing information where there are concerns about a child's safety or well-being.

**Police**

The Police are often the first point of contact with families in which domestic violence and abuse takes place. Officers attending incidents where children are present in the household are aware of the need to ensure the safety and well-being of such children and, in extreme cases, to take immediate protection measures and refer to Children's Social Care immediately. The Police will notify Children's Social Care of all incidents where there are children present in the house or children affected by the domestic violence and abuse.

Specialist Domestic Violence and Abuse and Child Protection officers work together, within a Police Public Protection Unit. All incidents of domestic and child abuse, reported to the Police are referred to the Unit, where a database is maintained, enabling links to be identified and case referrals to other agencies and support groups, to be made. The Unit acts as a 'single point of contact' for any professional or member of the public who wishes to discuss any domestic or child abuse issue or concern and takes lead responsibility for referring cases to Children's Social Care.

Incidents involving serious domestic violence and abuse, repeat victims and persistent offenders, are dealt with by the Unit and, where appropriate, cases involving children are investigated by both domestic violence and abuse and child protection officers. Where children are, or are normally, present in households where such incidents have occurred, these cases will be referred to Children's Social Care by the Unit.

**Health Service**

All health care professionals must recognise that their response to individuals experiencing domestic violence and abuse is of great importance. It is essential that there is an understanding of the inter-relationship which frequently exists, between domestic violence and abuse and the abuse and neglect of children.

Where professionals believe that children are at risk, procedures for Managing Individual Cases must be adhered to and a Referral made to Children's Social Care. The need to follow these procedures and should be discussed with the patient / client, and their consent obtained if possible. However, the interests of the child are paramount, and initiating child protection procedures is not conditional on obtaining consent and where there is evidence of domestic violence and abuse, the implications for any children in the household should be considered, including the possibility that the children may themselves be subject to violence or harm. Conversely, where it is believed that a child is being abused, those involved with the child and family should be alert to the possibility of domestic violence and abuse within the family.

**Probation Service**

The Probation Service is often asked to complete pre-sentence reports on offenders whose index offence is one of domestic violence and abuse or whose history contains a pattern of domestic violence and abuse. Such assessments often lead to supervision within the community on community based orders or, in some cases, on prison licence after release from custodial sentences. Nationally accredited programme's are currently being developed in addition to individual one to one packages. Such cases are routinely subject to multi-agency oversight and liaison with the Police, social services and other key voluntary and statutory agencies is critical to our role.

**Blackpool Children's Independent Domestic Violence Advisor (Children's IDVA)**

The Children's IDVA service offers specialised support to children and young people affected by domestic violence and abuse. This can be through witnessing domestic violence and abuse within the family unit, or direct experience (young people in their own relationships).

There are a number of aspects to our work and we endeavour to meet the needs of the individual. Examples of the Children's IDVA support include:

1:1 support - a chance for the individual to talk about their experiences in a safe environment using age appropriate resources, language and a flexible approach to meet each person's individual needs;

Individual and group work sessions around topics such as safety planning, confidence and self esteem building, safe and unsafe relationships, and domestic violence and abuse. This can be delivered in a range of settings such as schools, children's centres, community centres, and is tailored towards the age of the individual or group;

Peer support sessions - an opportunity to meet other young people who have had similar experiences, gain support from each other and reduce the feeling of isolation;

For children under five, the service supports the non-abusing parent in re-learning how to interact with their child/ren. This is aimed at rebuilding their relationships and establishing a positive parental role model;

Drop in sessions at a number of local high schools, to make our service easily accessible, to as many young people as possible;

Youth Forum - an opportunity for the children/young people to have their say on the issues and decisions which affect them. This is also an opportunity to meet new people and take part in activities and develop their social skills.

**Checks with and Referrals to Children's Social Care**

As stated there is frequently an inter-relationship between domestic violence and abuse and the abuse and Neglect of children and young people. Where there is domestic violence and abuse the implication of children remaining in the household should be considered. This includes the possibility that the children themselves may be subject to violence or other harm.

Each LSCB area must have a clear policy on when referrals should be made to the Children's Social Care. (See Blackburn with Darwen, Blackpool and Lancashire Continuum of Need and Thresholds Guidance.) Not all Referrals regarding domestic violence and abuse within a family will be considered as Child Protection Cases. However it is likely that where incidents are serious and frequent there will need to be an assessment of the child and families circumstances to address their support needs.

Where the Police are called to an incident of domestic violence and abuse or where information comes to the attention of other professionals involved regarding an incident of domestic violence and abuse and where there are children present or normally present within the household, a request should be made to Children's Social Care for a check to be made to determine whether the child is the subject of a Child Protection Plan. Where the child / young person is not the subject of a Child Protection Plan this should be logged as a contact unless there are serious concerns which would warrant a formal Referral under the Making a Referral to Children's Social Care Procedure (via Inter Agency Referral Form). This may lead to an investigation led by Children's Social Care. Where the child / young person is the subject of a Child Protection Plan or where a child who is resident at the address is an open case to the Children's Social Care details of the incident should be passed to the allocated social worker.

A serious incident of domestic violence and abuse which has been witnessed by a child or where children were present in the household at the time of the incident should result in a referral to Children's Social Care. Consideration should then be given to undertaking Section 47 Enquiries.

Concerns in respect of children should be referred to Children's Social Care, who will ensure all enquiries contain clear, precise and accurate information. Children's Social Care, in line with the Assessment Framework will make a decision as to the response within 24 hours. As such a Strategy Discussion is likely to be necessary.

Following completion of enquiries the allocated Social Worker should ensure that all professionals involved with the child / family and the parent / carers receive an outcome letter. If there are concerns regarding the outcome these should be addressed with the appropriate Social Work Team Manager.

Should there remain disagreement regarding the need for a Child Protection Conference the matter should be referred to the manager.

**Strategic Work and Partnerships**

In October 2005, the Local Government Association, (LGA) Association of Directors of Social Services (ADSS), Women's Aid and the Children and Family Court Advisory and Support Service (CAFCASS) published A Vision for Services for Children and Young People affected by Domestic Violence. This is commissioning guidance for Directors of Children's Services and LSCBs and it focuses on meeting the needs of children affected by domestic violence and abuse within the planning of integrated children's services. It provides a framework to ensure that the range of different needs that children/young people experience in relation to domestic violence and abuse are identified and addressed. It uses the now familiar tiers of intervention, and links needs and services to the five outcomes. It brings together the evidence from research, with best practice in the delivery of mainstream services, but also highlights the specialist services to which children require access. The guidance assists authorities to assure themselves that they have in place the services and responses that will satisfy the Every Child Matters Outcomes Framework.

A Domestic Violence and Abuse Strategic Partnership exists in all three areas, to raise awareness of domestic violence and abuse, to promote co-ordination between agencies in preventing and responding to violence, and to encourage the development of services for those who are subjected to violence or suffer its effects. There are Domestic Violence and Abuse Forums in most of the District Council Areas. They exist to raise awareness of issues and to promote the co-ordination and development of services. There should be a clear link between the Forum and the LSCB.

Domestic Violence Protection Orders and the Domestic Violence Disclosure Scheme

Domestic Violence Protection Orders

Domestic Violence Protection Orders (DVPOs) were implemented across England and Wales in March 2014.

They provide protection to victims by enabling the Police and magistrates to put in place protection in the immediate aftermath of a domestic violence incident.

With DVPOs, a perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

Before the scheme, there was a gap in protection, because Police could not charge the perpetrator for lack of evidence and so provide protection to a victim through bail conditions, and because the process of granting injunctions took time.

**Domestic Violence Disclosure Scheme (‘Clare’s Law’)**

The Domestic Violence Disclosure Scheme (DVDS) (also known as ‘Clare’s Law’) commenced in England and Wales in March 2014. The DVDS gives members of the public a formal mechanism to make enquires about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner. This scheme adds a further dimension to the information sharing about children where there are concerns that domestic violence and 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. 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 and other agencies to believe they pose a risk of harm to their partner, the Police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

For further information, see Domestic Violence Disclosure Scheme (GOV.UK website).

The Serious Crime Act 2015 creates a new offence of controlling or coercive behaviour in intimate or familial relationships. Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. Such behaviours might include:

Isolating a person from their friends and family;

Depriving them of their basic needs;

Monitoring their time;

Monitoring a person via online communication tools or using spyware;

Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;

Depriving them of access to support services, such as specialist support or medical services;

Repeatedly putting them down such as telling them they are worthless;

Enforcing rules and activity which humiliate, degrade or dehumanise the victim;

Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;

Financial abuse including control of finances, such as only allowing a person a punitive allowance;

Threats to hurt or kill;

Threats to a child;

Threats to reveal or publish private information (e.g. threatening to ‘out’ someone).

Assault;

Criminal damage (such as destruction of household goods);

Rape;

Preventing a person from having access to transport or from working.

**Drug Misusing Parents/Carers**

**The Impact on Children and Families**

A child's growth and development depends on a variety of interacting social and biological factors, which can be broadly grouped into three categories: conception and pregnancy, parenting, and the wider family and environment.

Hidden Harm - Responding to the Needs of Children of Problem Drug Users (ACMD 2003) outlines the way in which problem drug use can impact on the development of children in affected families.

Throughout their lives children may need the services of various professionals. Positive interventions at different stages of their growth and development can contribute to children and young people reaching their full potential. Effective collaboration, good joint working and a sharp focus on the family as a whole are essential if children of substance misusing parents are to receive appropriate care and support.

It is recognised that there may be barriers to agencies working together; however, these must be addressed to ensure that all agencies act together appropriately and at the right time in accordance with the needs of children and young people. All agencies have a part to play in helping to identify problems at an early stage. Basic information should be gathered about the family and household circumstances of those who misuse substances.

**Eight Golden Rules**

Problem substance users normally want to be good parents;

Problem substance users should be treated in the same way as other parents whose personal difficulties interfere with their ability to provide good parenting;

Base your judgements on evidence, not optimism;

There will be many aspects of the child's life that are nothing to do with drugs or alcohol and may be equally or more important;

Recognise that the parents are likely to be anxious. They may be worried that they could lose their children. Children, especially older ones, may also share similar anxieties;

Do not assume that abstinence will always improve parenting skills;

The family situation will not remain static, assessment should be revisited at least every six months or when ever new concerns arise; whichever is sooner;

Understand what is the child's experience of living with substance misusing parents; speak to them alone or with an advocate.

**Confidentiality and Information Sharing**

See Information Sharing and Confidentiality Procedure. As in all situations of actual or possible harm to children the right to share information overrides the individual's right to confidentiality.

**Assessments**

When assessing the well-being of a family, agencies must look at the parents' drug and/or alcohol use from the perspective of the child to understand the impact this has on the child's life and development. Each child should be considered on an individual basis. It is important to consider that parents often do not stop using drugs or alcohol when they have children although it can often be a strong motivator for change.

**Initial Screening Assessment**

All agencies which engage with adults with substance use, in any capacity, must ask the following questions:

Are you a parent?

How many dependent children are you responsible for?

If the adult is under the influence of a substance or if the adult is in custody or receiving medical attention, ask where are the children currently?

Agencies supporting adults who are problem substance users should in addition obtain the following information in their initial screening assessment:

The child(ren's) age and gender;

Who is their primary carer?

Which school or nursery do they attend, if aged two years or over?

Who else is living in the household?

Are there support agencies in touch with the family who are supporting the children (identify the child's Health Visitor, GP, School Nurse, Children's Centre, Drugs worker and, where involved, Social Worker). Is there is a Lead Professional?

How do parent(s) views the impact of their substance use on their child?

Can the extended family and / or friends can help?

Are there any other agencies voluntary or statutory available to help?

Is the parent/s willing to accept help?

Is there a risk of losing their accommodation?

Has a Early Help Assessment (EHA) been completed? If answer is no, do you now need to commence a Early Help Assessment ?

This information may be obtained through the course of normal agency work over a period of time or in one session specifically designed to do so, depending on the agency's remit and normal working practices. It is recognised that consultation with other agencies may be necessary to complete this assessment (Social Work, Health, Education, Housing, Voluntary Sector agencies.) Where there are immediate child safety issues these should be referred on to Children's Social Care or the Police.

During work with substance users who are parents; agencies should be alert to stresses arising from the substance use, which are likely to impact on children. Professionals should advise and discuss with parents the harmful impact of their continued substance misuse on their children.

When assessing parental substance misuse the following two models give an overview of the process. Examples of specific questions and areas for consideration and expansion are also detailed. To ensure good multi-agency working and information sharing, this assessment must be entered onto a Early Help Assessment in line with local guidance.

**Checklist**

All Staff should be able to answer the following questions:

Are children usually present at home visits, clinic or office appointments during normal school or nursery hours?

What reason has been given for the child being absent from school?

Is the child attending school/nursery regularly?

Is the child punctual for school/nursery?

Do parents think that their child knows about their drug use?

How do they know?

What arrangements have been made for the children when the parent goes to get illegal drugs or attends for supervised dispensing of prescription drugs?

How much money does the family spend on drug use? What % of the weekly income does this come to?

Is the income from sources presently sufficient to feed, clothe and provide for children in addition to obtaining substances?

Who will look after the children if the parent is arrested or is unable to care for them?

What arrangements are made for storing any drugs or prescription medication?

When deciding whether a child may need help, agencies should consider the following questions:

Are there any factors which make the children particularly vulnerable, e.g. very young child, other special needs such as physical illness, behavioural and emotional problems, psychological illness or learning difficulty, threatened or actual loss of accommodation?

Consider the needs of the unborn child.

Are there any protective factors that may reduce risk to the child? (It may be necessary to consult with specialist children's service workers to determine this.)

How does the child's health and development compare to that of other children of the same age and in similar situations?

What kind of help do you think the child needs?

Do the parents perceive any difficulties and how willing are they to accept help and work with professionals?

What do you think might happen to the child? What would make it more or less likely?

Is there suspicion of neglect, injury or abuse, now or in the past? What happened? What effect did/does that have on the child? Is it likely to recur?

Is the concern the result of a single incident, a series of incidents or a culmination of concerns over a period of time?

What does the child think? What do other family members think? How do you know?

Children in the Family - Provision of Good Basic Care

How many children are in this family?

What are their names and ages (wherever possible, include dates of birth)?

Are there any children living outside the family home and, if so, where? Why, and with whom?

Do the parents see any of the children as being particularly demanding?

Are there any other special circumstances such as illness, disability which need to be considered?

**For each child:**

Is there adequate food, clothing and warmth for the child? Are height and weight normal for the child's age and stage of development?

Is the child receiving appropriate nutrition and exercise?

Is the child's health and development consistent with their age and stage of development? Has the child received necessary immunisations? Is the child registered with a GP and a dentist? Do the parents seek health care for the child appropriately?

Does the child attend nursery or school regularly? If not, why not? Is s/he achieving appropriate academic attainment?

Does the child present any behavioural or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?

Who normally looks after the child?

Is the child engaged in age-appropriate activities?

Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities, etc)?

Is the care for the child consistent and reliable? Are the child's emotional needs being adequately met?

Is there a risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences for fine default)?

How does the child relate to unfamiliar adults?

Are there non-substance using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?

Does the child know about his/her parents substance use?

Is there evidence of drug/alcohol use by the child?

**Describing Parental Substance Use**

Identify sources of information, including conflicting reports, give consideration to negative impact on the child:

Specify drug of choice and how this is used, e.g. method, frequency quantity.

**Is the drug use by parent:**

Experimental - i.e. only used on a few occasions may be number of different drugs.

Recreational - i.e. not using every day may be at weekends only on pay day or on nights out. (Some agencies are getting away from using this term, gives a feel of safety.)

Chaotic - i.e. usually variety of substances and in varying amounts frequent periods of intoxication and withdrawal.

Dependent - i.e. using substance or substances every day. Experiences withdrawal when not using however may be controlled and not chaotic use (see Definitions section 10).

Identify whether the drug used is illicit or prescribed and whether use is regularly supplemented / 'topping up'

Does the user move between these types of drug use at different times?

Does the parent misuse alcohol?

What patterns of drinking does the parent have?

Is the parent a binge drinker with periods of sobriety? Are there patterns to their bingeing? i.e. weekends or at times of stress.

Is the parent a daily heavy drinker?

Does the parent use alcohol concurrently with other drugs?

How reliable is current information about the parent's drug use?

Is there a drug-free parent/non-problematic drinker, supportive partner or relative?

Is the quality of parenting or childcare different when a parent is using drugs and when not using?

Does the parent have any mental health problems alongside substance use? If so, how are mental health problems affected by the parent's substance use? Are mental health problems directly related to substance use?

Is there any history of self harm?

Is there any history of sexual abuse?

Is there any history of domestic abuse?

Are there known learning difficulties?

**Accommodation and Home Environment**

Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot, with sufficient bedding?

Are rent and bills paid? Does the family have any arrears or significant debts?

Is there any evidence of fuel poverty?

How long have the family lived in their current home/current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?

Is the household at risk of losing their accommodation? If yes, what action has been taken by the landlord?

Do other drug users / problem drinkers share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?

Is the family living in a drug-using / heavy drinking community?

If parents are using drugs, do children witness the taking of the drugs, or other substances?

Have the parent/s ever overdosed intentionally or accidentally?

Have any of the children witnessed their parents or other users having "overdosed"?

Are children exposed to intoxicated behaviour/group drinking?

Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

**Procurement of Drugs**

Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk such as street meeting places, flats, needle exchanges, adult clinics?

How much do the parents spend on drugs (per day? per week?) How is the money obtained?

Is this causing financial problems?

Do the parents sell drugs in the family home?

Are the parents allowing their premises to be used by other drug users?

Is/are the child/ren involved in the procurement of drugs?

Health Risks

Where in the household do parents store drugs / alcohol?

What precautions do parents take to prevent their children getting hold of their drug / alcohol? Are these adequate?

Do the children know where the drugs / alcohol are kept?

Does the child/ren witness the parent/s taking their medication either at home or at the pharmacy? (Risk of young children copying their parents.)

What do parent/s know about the risks of children ingesting methadone and other harmful substances?

Do parents know what to do if a child has or they suspect has consumed methadone or other drugs?

Do parents know what to do if a child has consumed a large amount of alcohol?

Are they in touch with local agencies that can advise on issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?

Is there a risk of HIV, Hepatitis B or Hepatitis C infection?

Blood-borne viruses (e.g. HIV, hepatitis B and C) are not in themselves issues for child protection and there is no evidence that child protection issues arise disproportionately in families affected by these viruses. Workers should seek specialist advice if issues about blood-borne viruses arise in the course of their work.

Are parents aware of increased risk of cot death if baby is co-sleeping when parents are using substances including prescribed or illicit drugs and alcohol (NB This also applies if sleeping on sofa or chair etc)?

If the Parent(s) Inject:

Where is the injecting equipment kept? In the family home? Are works kept securely?

Is injecting equipment shared?

Is a needle exchange scheme used?

How are syringes disposed of?

What do parent/s know about the health risks of injecting or using drugs?

If pregnant, are they aware of screening tests for blood borne viruses and appropriate immunisations?

**Family and Social Supports**

Do the parents primarily associate with other substance users, non-substance users or both?

Are relatives aware of parent(s) problem alcohol/drug use? Are they supportive of the parent(s) and/or/child(ren)?

Will parents accept help from relatives, friends or professional agencies?

Is social isolation a problem for the family?

How does the community perceive the family? Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

Have you considered the support of the Senior Parenting Practitioner (NB post primarily linked to Anti Social Behaviour (ASB) and referrals accepted where there are ASB concerns as well as other issues i.e. drugs/alcohol/mental health/domestic abuse) or family support services?

**Parent's Perception of the Situation**

What do parents think of the impact of the substance misuse on their children?

Is there evidence that the parents place their own needs and procurement of alcohol or drugs before the care and welfare of their children?

Do the parents know what responsibilities and power agencies have to support and protect children at risk?

**Child Centred Assessment**

In working with and assessing the needs of children with drug or alcohol using parents, the work that is undertaken with them should aim to establish what it feels like for the child(ren) to live in that household and to establish whether the child(ren) need information and/or support in dealing with the issues that impact upon and affect them.

In doing so, the worker should approach the child(ren) in a way which is appropriate to their age and development which enables the child to tell a story without putting them on the spot and forcing them to "tell tales." The worker should attempt to establish the child's level of awareness and understanding about substance misuse and the willingness of the child to provide information or answer questions. It is also important for the worker to try and establish what support the child(ren) needs and who might be an acceptable source for that help e.g. a friend or friend's parent, family member, concerned other and so on.

**Key Areas that could be Explored:**

What they do on a daily basis;

Whether or not they feel safe;

Where do they turn for help, protection and comfort;

What it is like when their parents are under the influence of drugs and/or alcohol;

What it is like when they are not;

What fears, hopes and anxieties they have about their parents' behaviour;

What they would most like to change;

What they would most like to stay the same;

Is there violence in the home;

Does anything else happen that frightens them;

Extent of caring responsibilities they might assume because of parental drug/alcohol use;

The extent to which developmental milestones are being met;

Are they being bullied at school?

**Analysis: Making Sense of the Information**

This is the most important part of the assessment process as a poor analysis of the information that has been collated will invariably lead to poor decision making and care planning. In making sense of the information that has been gathered, where that information should take the worker is framed in terms of the following questions:

Is the parents' drug or alcohol use significantly affecting parenting capacity?

Is the parents' drug or alcohol use and associated behaviour significantly impacting upon the child's health and safety, social, emotional and educational development?

What are the resources and strengths in this family and how might they impact on the care of the child?

What is the parents' understanding and attitude on the need for change?

What change might be acceptable and attainable?

What types of professional intervention will help reduce the harm to the children?

Consider the use of universal provision as the preferred option as this is often less stigmatising for the children.

Where, on the continuum of early help, children in need, children in need of protection, does this particular family sit?

**Outlined below are some suggestions which may assist the analysis component of the assessment:**

A chronology of significant events;

Who else is involved and why - a synthesis of current information, observations and any other assessments;

The views and perspectives of all interested parties, including children, parents, family, neighbours and members of the community and other professionals/agencies;

Checks to test the reliability of information/evidence and its sources;

Identify any other factors that may influence the assessment e.g. values of individual worker; parental attitudes and level of co-operation and honesty;

Evidence based judgements underpinned by research and theory relating to drug and/or alcohol use, child welfare and parenting;

Identify and utilise pooled knowledge, skills, resources and support networks.

Completion of the Grade Care Profile if neglect is the issue.

**Pregnancy and Neo-Natal Care**

**Introduction**

Pregnancy may act as a catalyst for change presenting a 'window of opportunity'. Drug users may not use general health services until late into pregnancy and this increases the health risks for both the mother and child. Individualised care will be provided for substance using women, in line with Polices and guidelines of the unit at which the women selects to access maternity care.

Attracting and maintaining women in drug treatment services is vital (Hepburn 1993) as follow-up studies demonstrate that the long-term outcome in women who enter a methadone treatment programme during pregnancy is better in terms of their pregnancy, childbirth and infant development, irrespective of continuing illicit drug use (Finnegan,1991). Women attending treatment services usually have better antenatal care and better general health than drug using women not in treatment, even if they are still using illicit drugs (Batey & Weissel 1993). Therefore Drug and Alcohol Services will prioritise all pregnant women with drug and or alcohol problems to allow for the earliest engagement possible.

Engagement of a drug and or alcohol using partner in treatment is an important aspect of enabling the pregnant women to achieve progress at the earliest possible stage.

**Management of Antenatal Care**

The key aims of management are to attract the women into health care treatment services, provide antenatal care and stabilize or reduce drug use to the lowest possible dose. Professionals should advise and discuss with parents the harmful impact of their continued substance misuse on their children and this should be recorded.

It is important that no agency worker advises a pregnant woman to stop using drugs or alcohol without first referring the matter to the midwifery service or discussion with the key worker in addiction services. The immediate withdrawal of such drugs or alcohol could result in premature birth or miscarriage.

Good co-ordination and information sharing between relevant parties is imperative. In Lancashire, please see the Multi-Agency Pre-Birth Protocol for more information.

In Blackburn with Darwen: Given the possibility of early delivery, it is recommended that a meeting is held between 24 weeks - 32 weeks gestation to ensure that care and support is appropriate to the needs of the woman the baby and her immediate family and that plans are in place for the family post-delivery. This should reduce the need for emergency child protection proceedings at birth. The parents should be informed about all meetings and supported and encouraged to attend.

Where agencies or individuals anticipate that the unborn baby may be at risk of Significant Harm, a referral to Children's Social Care must be made as soon as the concerns are identified. See Making a Referral to Children's Social Care Procedure for more information.

Effects of Substances on the Foetus and Baby.

It is important for clinicians to note that some of the effects of different drugs used during pregnancy are broadly similar and are largely non-drug specific. Intra-uterine growth retardation and pre-term deliveries contribute to increased rates of low birth-weight and increased prenatal mortality rate. These outcomes are multi-factorial and are also affected by factors associated with socio-economic deprivation, including smoking (Kaltenbach &Finnegan 1997).

Higher rates of early pregnancy loss and third-trimester placental abruption appear to be major complications of maternal cocaine use. Increased rates of stillbirth, neonatal death and sudden infant death syndrome are found. Heroin has been shown to have a direct effect on foetal growth and an association with pre-term delivery. It has also been shown to result in a higher rate of small-for-date babies, even when allowing for other compounding factors and the expression of neonatal abstinence syndrome (NAS). There is shown to be a significant correlation between methadone dose and NAS.

**Maternal Health Problems**

There are a number of health problems in pregnancy, which need to be discussed with the woman and reviewed throughout the pregnancy. These include general nutrition, risks of anaemia, dental hygiene and complications from chronic infection related to injection practice. These all contribute to the increased rate of obstetric complications and premature delivery found in drug using women. Drug using women are at high risk of antenatal and postnatal mental health problems.

**Management of Labour**

Each Hospital Trust has its own procedures for the management of labour.

**Neonatal Withdrawal**

Many babies will not need paediatric interventions, but it is important to have access to skilled neonatal paediatric care. However, all babies of substance using mothers will be subject to a withdrawal scoring sheet, which some women might interpret as intervention.

Signs of withdrawal from opiates are vague and multiple and tend to occur 24-72 hours after delivery. They include a spectrum of symptoms such as a high-pitched cry, rapid breathing, hungry but ineffective sucking, and excessive wakefulness. At the other end of the spectrum symptoms include hypertonicity and convulsions but these are not common. Neonatal withdrawal can be delayed for up to 7-10 days if the woman is taking methadone in conjunction with benzodiazepines. Benzodiazepine use causes more prolonged symptoms, including respiratory problems and respiratory depression.

**Postnatal Management**

Breastfeeding should be encouraged, even if the mother continues to use drugs, except where she uses a very high dose of benzodiazepines, crack/cocaine. Specialist advice should be sought if she is HIV positive. Methadone treatment is not a contraindication to breastfeeding.

Health professionals should note that the care of the pregnant drug user and the safe delivery of the baby is just the start of care. Continuing support, which may need to include parenting advice and skills training, may be desirable both pre-and post-discharge if the ideal outcome of maintaining mother and child together is to be achieved.

**Discharge Planning**

To ensure that care and support continues on discharge a planning meeting should be considered and arranged on an individual basis if required. Prior to discharge all information should be reviewed and plans documented in the case notes, with liaison on discharge to relevant agencies. Relevant agencies will be notified of the discharge plan and the midwifery services will contact Substance Misuse Services to ensure continuation of prescribed medication. Details of the discharge plan should be entered onto the Early Help Assessment.

**Prescribing Drugs for Pregnant Drug Users**

Substitute prescribing can occur at any time in pregnancy and is lower risk than continuing illicit use. It has the advantage of allowing engagement and therefore identification of both health and social needs as well as offering the opportunity for brief interventions and advice to improve outcomes. (Note specialist advice must always be sought.)

Expectant mothers who are drinking dependently should be referred as a matter of priority to a Drug and Alcohol Service and not be advised to stop without supervision due to the risk of withdrawal.

**Fabricated Induced Illness**

**Definition**

Fabricated or Induced Illness (FII) (Known previously as Munchhausen Syndrome by Proxy; other synonyms: Factitious disorder imposed on another) is a spectrum of conditions where a child experiences or likely to experience significant harm and impairment due to the health care seeking behaviour and actions of the caregiver(s), usually the mother. Such behaviour and actions may take one or more of the following forms:

Erroneous (incorrect or misleading) reporting of medical history, symptoms or signs, with or without an intention to deceive which may include

False reporting of non-existing symptoms and signs,

Exaggeration of existing symptoms and signs,

Misinterpretation of real events on the basis of mistaken belief about their meaning.

Deception by use of hand including:

Falsification of medical records

Interference with investigations, specimens, intravenous lines, ….etc

Inducing illness in the child by overdosing, poisoning (e.g. Adding salt to baby’s feed), suffocation, none administration of medications (e.g. inhalers for asthma, medication for epilepsy, thyroxin for under active thyroid gland), …. Etc.

Please see detailed guidance in the link below:

<http://panlancashirescb.proceduresonline.com/pdfs/fab_ind_ill.pdf>

**Female Genital Mutilation (FGM)**

**Definition**

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

FGM has been a criminal offence in the U.K. since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence for the first time for UK nationals, permanent or habitual UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

The rights of women and girls are enshrined by various universal and regional instruments including the Universal Declaration of Human Rights, the United Nations Convention on the Elimination of all Forms of Discrimination Against Women, the Convention on the Rights of the Child, the African Charter on Human and Peoples’ Rights and Protocol to the African Charter on Human and Peoples’ Rights on the rights of women in Africa. 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.

FGM has been classified by the World Health Organisation (WHO) into four types:

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);

Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina);

Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the

clitoris; and

Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

For more detail, please refer to the Multi-agency statutory guidance on female genital mutilation April 2016 (GOV.UK).

**Indicators**

These indicators are not exhaustive and whilst the factors detailed below may be an indication that a child is facing/at risk of FGM, it should not be assumed that is the case simply on the basis of someone presenting with one or more of these warning signs. These warning signs may indicate other types of abuse such as forced marriage or sexual abuse that will also require a multi-agency response. See also statutory guidance Annex B: Risk, for details.

The following are some signs that the child may be at risk of FGM:

A female child is born to a woman who has undergone FGM or whose older sibling or cousin has undergone FGM;

The family belongs to a community in which FGM is practised or have limited level of integration within UK community;

The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;

If a female family elder is present, particularly when she is visiting from a country of origin, and taking a more active / influential role in the family;

The family makes preparations for the child to take a holiday, e.g. arranging vaccinations, planning an absence from school;

The child talks about a ‘special procedure/ceremony’ that is going to take place;

An awareness by a midwife or obstetrician that the procedure has already been carried out on a mother, prompting concern for any daughters, girls or young women in the family;

Repeated failure to attend or engage with health and welfare services or the mother of a girl is very reluctant to undergo genital examination including cervical smears;

Where a girl from a practising community is withdrawn from Sex and Relationship Education (also known to withdrawn from mainstream education completely to either home education/religious education institutions) - they may be at risk from their parents wishing to keep them uninformed about their body and rights.

Consider whether any other indicators exist that FGM may have or has already taken place, for example:

The child has changed in behaviour after a prolonged absence from school;

The child has health problems, particularly bladder or menstrual problems;

The child has difficulty walking, sitting or standing and may appear to be uncomfortable.

A Strategy Discussion will determine the need for a medical assessment and where it is believed that FGM has already taken place.

It should be remembered that this will have lifelong consequences, and can be highly dangerous at the time of the procedure and directly afterwards.

If you are worried about a girl under 18 who is either at risk of FGM or who you suspect may have had FGM, you should share this information with Children’s social care or the Police immediately, whichever is most appropriate see Protection and Action to be Taken. See also Female Genital Mutilation Pan - Lancashire Multi-Agency Pathway for Children.

From the 31st October 2015, regulated professionals in health and social care and teachers/teaching assistants in England and Wales have a duty to report ‘known’ cases of FGM in under 18s to the Police see Mandatory Reporting of FGM.

Professionals must take into consideration that by alerting the girl’s or woman’s family to the fact that she is disclosing information about FGM may place her at increased risk of harm and professionals should therefore take sufficient steps to minimise this risk.

It should not be assumed that families from practising communities will want their girls and women to undergo FGM, however a multi-agency response must take place to establish the risk if any.

**NHS Actions**

Since April 2014 NHS Acute hospital Trusts have been required to record:

If a patient has had Female Genital Mutilation;

If there is a family history of Female Genital Mutilation;

If a Female Genital Mutilation-related procedure has been carried out on a patient.

Since September 2014 all acute hospitals have been required to report this data centrally to the Department of Health on a monthly basis. This was the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered Female Genital Mutilation and actively support prevention.

A midwife/obstetrician/gynaecologist/General Practitioner may become aware that Female Genital Mutilation has occurred when treating a female patient. This should trigger concern for other females in the household.

For further information, see Female Genital Mutilation Datasets (NHS).

**Mandatory Reporting of FGM**

From the 31st October 2015, regulated professionals in health and social care and teachers/teaching assistants in England and Wales have a duty to report ‘known’ cases of FGM in under 18s which they identify in the course of their professional work to the Police. Following consultation with social care professionals as well as other relevant professionals, only then will the Police take action to ensure the girl/young woman is safe and her needs are prioritised.

‘Known’ cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within Section 1(2)(a) or (b) of the FGM Act 2003.

A failure to report the discovery in the course of their work could result in a referral to their professional body. The Home Office has produced guidance Mandatory Reporting of Female Genital Mutilation – procedural information to support this duty and a fact sheet on the New Duty for Health and Social Care Professionals and Teachers/teaching assistants to Report Female Genital Mutilation (FGM) to Police.

If there are suspicions that a girl under the age of 18 years may have undergone FGM or is at risk of FGM professionals must still report the issue by following their internal safeguarding procedures. Professionals must share the information about their concerns, potential risk and/or the actions which are to be taken. Next steps should be discussed with the safeguarding lead and if necessary a social care referral made.

**Protection and Action to be Taken**

Where concerns about the welfare and safety of a child or young person have come to light in relation to FGM a referral to Children’s social care should be made in accordance with Making a Referral to Children's Social Care Procedure.

Children’s Social Care will undertake an assessment and, jointly with the Police, will undertake a Section 47 Enquiry if they have reason to believe that a child is likely to suffer or has suffered FGM. A strategy discussion/meeting should include the relevant Health professionals and, if the child is of school age, the relevant school representative.

Where a child has been identified as having suffered, or being likely to suffer, Significant Harm, it may not always be appropriate to remove the child from an otherwise loving family environment. Parents and carers may genuinely believe that it is in the girl’s best interest to conform to their prevailing custom. Professionals should work in a sensitive manner with families to explain the legal position around FGM in the UK. The families will need to understand that FGM and re-infibulation (the process of resealing the vagina after childbirth) is illegal in the UK and that if they are insistent upon carrying out the practice, it can lead to child protection and criminal justice actions taken against them. Interpretation services should be used if English is not spoken or well understood and the interpreter should not be an individual who is known to the family.

Where a child appears to be in immediate danger of mutilation, legal advice should be sought and consideration should be given, for example, to seeking a Female Genital Mutilation Protection Order, an Emergency Protection Order or a Prohibited Steps Order, making it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

The 2003 Female Genital Mutilation Act makes it illegal for any residents of the UK to perform FGM within or outside the UK. The punishment for violating the 2003 Act carries 14 years imprisonment, a fine or both.

If the outcome of social care enquiries is that female child may be at risk of future harm, community agencies (school nurses, GPs, schools etc.) with regular contact with the child should be informed of any risks and requested to make an immediate referral should any of the indicators above are identified.

**Issues**

**Where is FGM Practised?**

As a result of immigration and refugee movements, FGM is now being practiced by ethnic minority populations in other parts of the world, such as USA, Canada, Europe, Australia and New Zealand.

FORWARD estimates that as many as 6,500 girls are at risk of FGM within the UK every year.

The most recent estimates of prevalence within England & Wales down to local authority level can be found at the City University London website.

The report draws on prevalence data from across 27 countries where FGM is known to be part of cultural practices. From census and education data it is known that across Pan-Lancashire residents originate from at least two-thirds of FGM practising countries (including eight out of the eleven countries where FGM prevalence rates are above 70% in women.

The City University London and Equality Now report along with the indicators outlined above will allow professionals to analyse the likelihood of risk and the types of risk girls may face.

There is no Biblical or Koranic justification for FGM and religious leaders from all faiths have spoken out against the practice - There are however some extreme views within some religious teachings that FGM is required to maintain female chastity and purity which may therefore perpetuate the practice and cause conflict within families and communities around FGM practice.

**Consequences of FGM**

Depending on the degree of mutilation, FGM can have a number of short-term health implications:

Severe pain and shock;

Infection;

Urine retention;

Injury to adjacent tissues;

Immediate fatal haemorrhaging.

Long-term implications can entail:

Extensive damage of the external reproductive system;

Uterus, vaginal and pelvic infections;

Cysts and neuromas;

Increased risk of Vesico Vaginal Fistula;

Complications in pregnancy and child birth;

Psychological damage;

Sexual dysfunction;

Difficulties in menstruation.

In addition to these health consequences there are considerable psycho-sexual, psychological and social consequences of FGM.

**Justifications of FGM**

The justifications given for the practise are multiple and reflect the ideological and historical situation of the societies in which it has developed. Reasons include:

Custom and tradition;

Religion, in the mistaken belief that it is a religious requirement;

Preservation of virginity/chastity;

Social acceptance, especially for marriage;

Hygiene and cleanliness;

Increasing sexual pleasure for the male;

Family honour;

A sense of belonging to the group and conversely the fear of social exclusion;

Enhancing fertility.

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. An accredited female interpreter may be required. Any interpreter should ideally be appropriately trained in relation to FGM, and in all cases should not be a family member, not be known to the individual, and not be someone with influence in the individual’s community.

In light of this, professionals must give careful thought and consideration to developing a safety and support plan for the girl/woman prior to meeting with her. If a girl/woman is seen by someone within the community who she perceives as ‘hostile’ this may pose a risk to her safety. By mutually agreeing in advance another reason why they are there and/or why they are meeting could potentially minimise this risk.

**Further Information**

Female Genital Mutilation Pan - Lancashire Multi-Agency Pathway for Children

AFRUCA (Child Protection of African Children)

Forward (Foundation for Women's Health Research and Development)

Multi-Agency Statutory Guidance on Female Genital Mutilation

FGM Protection Orders: Factsheet

Female Genital Mutilation and its Management: Royal College of Obstetricians and Gynaecologists 2015

Female Genital Mutilation: Resource Pack (GOV.UK)

Mandatory Reporting of Female Genital Mutilation – procedural information

Working Together to Safeguard Children 2015

Female Genital Mutilation Risk and Safeguarding - Guidance for Professionals (Department of Health)

FGM Mandatory Reporting Duty (Department of Health)

FGM Mandatory Reporting Duty - What you need to do (Department of Health)

FGM – Supporting Girls, Information for Patients (NHS)

Statement opposing Female Genital Mutilation (Health passport)

Female Genital Mutilation (FGM)

**Law**

The Female Genital Mutilation (FGM) Act was introduced in 2003 and came into effect in March 2004. The act:

Makes it illegal to practice FGM in the UK;

Makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country;

Makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad;

Has a penalty of up to 14 years in prison and/or, a fine.

The Serious Crime Act 2015 has amended the Female Genital Mutilation Act 2003

Created a new offence of failing to protect a girl from FGM with a penalty of up to 7 years in prison or a fine or both. - A person is liable if they are “responsible” for a girl at the time when an offence is committed. This will cover someone who has “parental responsibility” for the girl and has “frequent contact” with her and any adult who has assumed responsibility for caring for the girl in the manner of a parent. This could be for example family members, with whom she was staying during the school holidays;

Introduced Female Genital Mutilation Protection Orders (“FGMPO”) - breaching an order carries a penalty of up to five years in prison. The terms of the order can be flexible and the court can include whatever terms it considers necessary and appropriate to protect the girl or woman;

Allowing for the anonymity of victims of FGM – prohibiting the publication of any information that could lead to the identification of the victim. Publication covers all aspects of media including social media;

Extended the extra-territorial reach of Female Genital Mutilation (FGM) offences to include “habitual residents” of the UK;

Created a new duty of Mandatory Reporting of Female Genital Mutilation for regulated professionals in health and social care professionals and teachers/teaching assistants in England and Wales which came into force on the 31st October 2015

**Forced Marriage**

**Introduction**

A 'forced' marriage (as distinct from a consensual "arranged" marriage) is defined as one which is conducted without the valid consent of both of the parties and where duress is a factor. Duress includes both physical and emotional pressure and cannot be justified on religious or cultural grounds. Forced marriage is child abuse and can put children and young people at risk of physical, emotional and sexual abuse. Children's Social Care has a duty to make enquiries into allegations of abuse or neglect against a child under s.47 Children Act 1989 (and where appropriate s.17 of the Act);

The majority of cases of forced marriage encountered in the UK involve South Asian families. This is partly a reflection of the fact that there is a large population in the UK. Indeed, it is clear that forced marriage is not solely a South Asian problem and there have been cases involving families from East Asia, the Middle East, Europe, and Africa. Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British citizen being sent abroad. Most cases involve young women and girls aged between 13 and 30, although there is evidence to suggest that as many as 15 per cent of victims are male;

The term "Forced Marriage" can cover a variety of crimes including assault, imprisonment and murder where the person is being punished by their family or community for actually or allegedly undermining what the family or community believes to be the correct code of behaviour and therefore bringing 'shame' or 'dishonour' onto the family or community. (Home Office)

Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions where it is appropriate to use both child and adult protection frameworks. For example, some 16 and 17 year olds may not wish to enter the care system but prefer to access refuge accommodation. Victims aged 16 and over should be assessed using the CAADA/The National Police Chief’s Council DASH and, if assessed as high risk, referred to the MARAC;

All professionals working with victims of forced marriage and 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 professionals working within statutory agencies need to be aware of their responsibilities and obligations when they come across forced marriage cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted;

Children's Social Care has a duty to make enquiries into allegations of abuse or neglect against a child under Section 47 Children Act 1989. Forced marriage is child abuse and can put children and young people at risk of physical, emotional and sexual abuse;

Mediation and involving the family can place a child or young person in danger and should not be undertaken as a response to forced marriage. This 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.

**Motives Prompting Forced Marriage**

Parents who force their children to marry often justify their behaviour as protecting their children, building stronger families, and preserving cultural or religious traditions. They do not see anything wrong in their actions. Forced Marriage cannot be justified on religious grounds; every major faith condemns it and freely given consent is a prerequisite of Christian, Jewish, Hindu, Muslim and Sikh marriages. Whilst it is important to have an understanding of the motives that drive parents to force their children to marry, these motives should not be accepted as justification for denying the child the right to choose a marriage partner. Forced marriage should be recognised as a human rights abuse;

Some key motives that have been identified are:

Controlling unwanted behaviour and sexuality (including perceived promiscuity, or being gay, lesbian, bisexual or transgender) - particularly the behaviour and sexuality of women;

Protecting 'family honour';

Responding to peer group or family pressure;

Attempting to strengthen family links;

Ensuring land, property and wealth remain within the family;

Protecting perceived cultural or religious ideals (which can often be misguided or out of date);

Preventing unsuitable relationships, e.g. outside the ethnic, cultural, religious or caste group;

Assisting claims for residence and citizenship;

Fulfilling long standing family commitments.

**The Legal Position**

In 2004, the Government's definition of domestic violence was extended to include acts perpetrated by extended family members as well as intimate partners. Acts such as forced marriage and other so-called 'honour crimes' which can include abduction and homicide, can now come under the definition of domestic violence. Many of these acts are committed against children. Perpetrators can be prosecuted for offences including threatening behaviour, assault, kidnap, abduction, imprisonment and murder. Sexual intercourse without consent is rape;

Sexual intercourse without consent is rape, regardless of whether this occurs within the confines of a marriage;

In addition, the Forced Marriage (Civil Protection) Act 2007, which was implemented in November 2008, makes provision for protecting children, young people and adults from being forced into marriage without their full and free consent (through Forced Marriage Protection Orders);

Anyone threatened with forced marriage or forced to marry against their will can apply for a Forced Marriage Protection Order. Such an order can be granted to prevent a marriage occurring or, where a forced marriage has already taken place, to offer protective measures. Orders may contain prohibitions (e.g. to stop someone from being taken abroad), restrictions (e.g. to hand over all passports and birth certificates and not to apply for a new passport), requirements (e.g. to reveal the whereabouts of a person or to enable a person to return to the UK within a given timescale) or such other terms as the court thinks appropriate to stop or change the conduct of those who would force the victim into marriage. A power of arrest may be added where violence is threatened;

Third parties such as relatives, friends, voluntary workers and Police officers can apply for a protection order with the leave of the Court. Since 1 November 2009, local authorities can apply for a protection order for a vulnerable adult or child without the leave of the court;

For further advice and information about how to make such an application, see the Guidance for Local Authorities on Applying for Forced Marriage Protection Orders, published by the Ministry of Justice in November 2009.

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 to 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.

**Symptoms of Risk Factors**

The factors below, collectively or individually may be an indication that a young person fears they may be forced to marry, or that a forced marriage has already taken place:

Education - truancy from lessons, low motivation in school, poor exam results, extended periods of 'authorised absence' for sickness or oversees family commitments, unofficial withdrawal from school, history of older siblings missing education and marrying early;

Health - self-harm, attempted suicide, eating disorders, depression, isolation;

Employment - poor performance, poor attendance, limited career choices, not allowed to work, unreasonable financial control e.g. confiscation of wages/income;

Family history - siblings forced to marry, family disputes, domestic violence and abuse, running away from home, unreasonable restrictions e.g. house arrest.

See also the Multi-agency Practice Guidelines on Forced Marriage Chart of Potential Warning Signs or Indicators.

**Dealing with Concerns and the "One Chance Rule"**

Forced marriage is abusive and when it concerns children and young people under the age of 18 years should be dealt with. Any agency becoming aware that a child is to be forced into marriage should make a referral to Children's Social Care, under the Referrals Procedure. A flowchart for the management of these cases can be found below;

All professionals working with victims of forced marriage 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 professionals working within statutory agencies need to be aware of their responsibilities and obligations when they come across forced marriage cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted;

Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions where it is appropriate to use both child and adult protection frameworks. For example, some 16 and 17 year olds may not wish to enter the care system but prefer to access refuge accommodation. Victims aged 16 and over should be assessed using the CAADA Risk Identification Checklist & Quick Start Guidance for Domestic Abuse, Stalking and Honour-Based Violence (DASH) and, if assessed as high risk, referred to the MARAC.

**Notes of Caution**

Mediation and involving the family can place a child or young person in danger and should not be undertaken as a response to forced marriage: this 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;

Extreme caution must be exercised. Do not discuss concerns about forced marriage with the young person's family or friends, or share information outside child protection Information Sharing and Confidentiality Procedures without the express consent of the young person. Such action could place a child or young person at increased risk. If approached parents may deny that the young person is being forced to marry, move the young person, expedite any travel arrangements and bring forward the forced marriage;

If there are concerns that a child (male or female) is in danger of a forced marriage, local agencies and professionals should contact the Forced Marriage Unit where experienced caseworkers will be able to offer support and guidance (020 7008 0230). The Police and Children's Social Care should also be contacted. All those involved will want to bear in mind that mediation as a response to forced marriage can be extremely dangerous. Refusal to go through with a forced marriage has, in the past, been linked to so-called 'honour crimes'.

**Gambling**

Holders of gambling premises licences or Gambling Permits, and personal licences have a statutory responsibility to promote the protection of children (and other vulnerable persons) from being harmed or exploited by gambling in of their premises.

The protection of children from harm requires the proactive involvement (and sometimes training) of licensees, management and staff to ensure that the needs of under 18's are considered and addressed in the day-to-day operation of the premises. Family-friendly premises benefit from a loyal customer base with time and money to spend, but like anybody customers have their own set of needs. Premises that want to profit by catering for families must ensure the way they operate meets the needs of under 18s.

There are premises which will want to provide activities that are not suitable for children and those children and young people will therefore be excluded:

From the area of the premises where the activities take place

From the premises as a whole; at the time the activities take place; or

At all times.

All licensing applications are screened by officers from Children's Social Care on behalf of the Local Safeguarding Children Board.

The Portman Group offers substantial advice and suggestions related to steps licensees can undertake which directly relate to promoting the licensing objectives including but not limited to age identification schemes.

**Gang, Group Activity and Criminal Exploitation Affecting Children/ County Lines**

**Definition**

Defining a gang is difficult. They tend to fall into three categories: peer groups, street gangs and organised crime groups. It can be common for groups of children and young people to gather together in public places to socialise, and although some peer group gatherings can lead to increased antisocial behaviour and low level youth offending, these activities should not be confused with the serious violence of a street gang.

A street gang can be described as a relatively durable, predominantly street-based group of children who see themselves (and are seen by others) as a discernible group for whom crime and violence is integral to the group's identity.

A street gang will engage in criminal activity and violence and may lay claim over territory (not necessarily geographical for example it could include an illegal economy territory). They have some form of identifying structure featuring a hierarchy usually based on age, physical strength, propensity to violence or older sibling rank. There may be certain rites involving antisocial or criminal behaviour or sex acts in order to become part of the gang. They are in conflict with other similar gangs.

An organised criminal group is a group of individuals normally led by adults for whom involvement in crime is for personal gain (financial or otherwise). This involves serious and organised criminality by a core of violent gang members who exploit vulnerable young people and adults. This may also involve the movement and selling of drugs and money across the country, known as ‘county lines’ because it extends across county boundaries and is coordinated by the use of dedicated mobile phone lines. It is a tactic used by groups or gangs to facilitate the use of vulnerable people or children to sell drugs in an area outside of the area in which they live, which reduces their risk of detection.

Selling drugs across **county lines** often involves the criminal exploitation of children and young people. Child criminal exploitation, like other forms of abuse and exploitation, is a safeguarding concern and constitutes abuse even if the young person appears to have readily become involved. Child criminal exploitation is typified by some form of power imbalance in favour of those perpetrating the exploitation and usually involves some form of exchange (e.g. carrying drugs in return for something). The exchange can include both tangible (such as money, drugs or clothes) and intangible rewards (such as status, protection or perceived friendship or affection). Young people who are criminally exploited are at a high risk of experiencing violence and intimidation and threats to family members may also be made. Gangs may also target vulnerable adults and take over their premises to distribute Class A drugs in a practice referred to as ‘cuckooing’.

Young people can become indebted to the gang/groups and then exploited in order to pay off debts. Young people who are criminally exploited often go missing and travel to other towns (some of which can be great distances from their home addresses). They may have unexplained increases in money or possessions, be in receipt of an additional mobile phone and receive excessive texts or phone calls.

White British children are often targeted because gangs perceive they are more likely to evade police detection and some children may be as young as 12, although 15 to 16 years old is the most common age range. The young people involved may not recognise themselves as victims of any abuse, and can be used to recruit other young people.

It is important to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a young person or vulnerable adult does not make them any less of a victim.

If a young person is arrested for drugs offences a long way from home in an area where they have no local connections and no obvious means of getting home, this should trigger questions about their welfare and they should potentially be considered as victims of child criminal exploitation and trafficking rather than as an offender. Agencies also need to be proactive and make contact with statutory services in the young person’s home area to share information.

Where there are concerns that children are victims of child criminal exploitation they should be referred to the National Referral Mechanism - see Modern Slavery Procedure, Referring a Potential Victim of Modern Slavery to the National Referral Mechanism (NRM).

There is a distinction between organised crime groups and street gangs based on the level of criminality, organisation, planning and control. However, there are significant links between different levels of gangs for example street gangs can be involved in drug dealing on behalf of organised criminal groups Young men and women may be at risk of sexual exploitation in these groups.

Children may be involved in more than one 'gang', with some cross-border movement, and may not stay in a 'gang' for significant periods of time. Children rarely use the term 'gang', instead they used terms such as 'family', 'breddrin', 'crews', 'cuz' (cousins), 'my boys' or simply 'the people I grew up with'.

Safeguarding should focus on both young people who are / vulnerable of making the transition to gang involvement as well as those already involved in gangs. Practitioners should be aware of particular risks to young people involved in gangs from violence and weapons; drugs and sexual exploitation.

**Risks**

The risk or potential risk of harm to the child may be as a victim, a gang member 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 poverty or mental health problems.

A child who is affected by gang activity, criminal exploitation or serious youth violence can be at risk of significant harm through physical, sexual and emotional abuse. Girls 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 for females and they are more likely to have been coerced into involvement with a gang through peer pressure than their male counterparts.

There is 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.

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.

**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;

Going missing;

Being found by Police in towns or cities many miles from their home;

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, criminal exploitation 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 are linked to their involvement in carrying out drugs along county lines. There may be gang-associated child sexual exploitation and relationships which can be strong pull factors for girls who go missing.

In suspected cases of radicalisation, social workers and local authorities have 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.

**Protection and Action to be Taken**

Any agency or practitioner who has concerns that a child may be at risk of harm as a consequence of gang activity including criminal exploitation should contact Children’s Social Care or the police for the area in which the child is currently located. The Making a Referral to Children's Social Care Procedure should be followed. An Early Help Assessment 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 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 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 (for example in the Police or Youth Offending Service), 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 and being criminally exploited. There may be a need to review their Care Plan in light of the assessment and to provide additional support.

Where there are concerns about a child or young person being criminally exploited (for example If a young person is arrested for drugs offences away from home in an area where they have no local connections and with no obvious means of getting home) the Police and Children’s Social Care, from the first point of contact with the young person, should consider whether they are victims of child criminal exploitation or trafficking and pursue a safeguarding, rather than criminal justice, response.

Children are often 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.

If there is a possible “threat to life”,the Police may consider it appropriate to issue an Osman Warning. In these circumstances this should trigger an automatic referral by the Police to Children’s Social Care, (see the Making a Referral to Children's Social Care Procedure) 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.

Any decision not to refer a child should be actively reviewed to allow a referral to Children’s 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 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) 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). Gang injunctions 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.

**Issues**

Children involved in gangs may be known to other services for offending behaviour or school exclusion.

Girls and young women involved with gangs can be affected by sexual violence, domestic violence, drug and alcohol misuse, school exclusion and going missing from home. Girls will often be controlled and manipulated by male gang members and sexual violence is a common feature of the experience of girls involved with gangs. Sisters or female family members who are not actively involved with gangs can be targeted and sexually assaulted by rival gangs.

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. This may provide opportunities for preventative work to be undertaken with children.

**Historical Abuse Allegations**

**Introduction**

Allegations of child abuse are sometimes made by adults and children many years after the 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 is continuing against other children may trigger the allegation.

These cases 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. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for children.

The Children's Social Care in the area where the alleged incident took place, has case responsibility and should arrange a Strategy Discussion to determine any further action required.

**Significance**

Organisational responses to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to current 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 will still take place despite the fact that the allegations are historical in nature and may have taken place many years ago.

An allegation may be made against (for example) a foster carer, adoptive parent, residential care staff, teacher, doctor, Police officer, volunteer or any other person who currently has, or previously had contact with children and young people. The alleged abuse may not have been an isolated incident. If it comes to light that the historical abuse is part of a wider setting of institutional or organised abuse, the case should be dealt with according to the procedures in Complex (Organised or Multiple) Abuse Procedure.

**Action to Safeguard**

As soon as it is apparent that an adult is revealing childhood abuse, the professional involved must explain that relevant information will need to be shared with the Police in order to safeguard children. They must record what has been said by the service user, and the responses given by the worker. A Chronology should be undertaken and all records must be dated and the authorship made clear by a legible signature or name.

If possible, the professional should establish if the adult is aware of the alleged perpetrators recent or current whereabouts and contact with children.

Whilst an adult service user should be asked whether s/he wants a Police investigation it should be made clear that dependent upon the nature of the information provided the worker may need to share this information with the Police if it will help to protect children. Adult service users must be reassured that the Police Protection Unit is able and willing to undertake such work even for those adults who are vulnerable as a result of mental health or learning difficulties.

Consideration must be given to the therapeutic needs of the adult and reassurance given that, even without her/his direct involvement all reasonable efforts will be made to look into what s/he has reported.

The worker should:

Inform the Police and establish if there is any knowledge regarding the alleged perpetrator's current contact with children;

Institute a Section 47 Enquiry if the alleged perpetrator is believed to be currently caring for, or having access to children. This will include making the necessary referral to the area where the alleged perpetrator is known to live.

**Honour Based Abuse**

**Introduction**

The definition of Honour based abuse is:

A variety of crimes including assault, imprisonment and murder where the person is being punished by their family or community for actually or allegedly undermining what the family or community believes to be the correct code of behaviour and therefore bringing 'shame' or 'dishonour' onto the family or community." (Home Office)

'A crime or incident, which has or may have been committed, to protect or defend the honour of the family and/or community'. (ACPO Working Definition 2008)

All professionals working with victims of honour based abuse 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 professionals working within statutory agencies need to be aware of their responsibilities and obligations when they come across these cases.

When a case of HBA is first reported it is important to obtain as much information as possible as there may not be another opportunity for the individual reporting to make contact. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted.

**Assessment Tool**

The CAADA Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and Honour-Based Violence (DASH).

Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions where it is appropriate to use both child and adult protection frameworks. For example, some 16 and 17 year olds may not wish to enter the care system but prefer to access refuge accommodation. Victims aged 16 and over should be assessed using the CAADA/The National Police Chief’s Council DASH and, if assessed as high risk, referred to the MARAC.

This Assessment Tool can be used to identify the risk of violence or abuse. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also used for lesbian, gay, bisexual relationships and for situations of "honour?-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

The purpose of the tool is to give a consistent and simple tool for practitioners who work with adult victims in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

**Hospital Stays for Children Where there are Welfare Concerns**

**Introduction**

The National Service Framework for Children, Young People and Maternity Services (NSF) (2004) sets out standards for hospital services. Standard 6 of the NSF is to be taken alongside the hospital standard, which was published in 2003 to meet the commitment made in the Government's response to the report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol. The Healthcare Commission has undertaken an improvement review of the NHS implementation of the hospital standard.

**Considerations When Child is in Hospital**

When children are in hospital, this should not in itself jeopardise the health of the child or young person further. The NSF requires hospitals to ensure that their facilities are secure and regularly reviewed. There should be policies relating to breaches of security and involving the Police. The Local Authority where the hospital is located is responsible for the welfare of children in its hospitals.

Children should not be cared for on an adult ward. The NSF Standard for Hospital Services requires care to be provided in an appropriate location, and in an environment that is safe and well suited to the age and stage of development of the child or young person. Hospitals should be child-friendly, safe and healthy places for children. Wherever possible, children should be consulted about where they would prefer to stay in hospital, and their views should be taken into account and respected. Hospital admission data should include the age of children, so that hospitals can monitor whether children are being given appropriate care in appropriate wards.

**Actions to Safeguard**

Section 85 of the Children Act 1989 requires Hospital and Health Trust with in-patient care to notify the 'Responsible Authority' - i.e. the local authority for the area where the child is ordinarily resident, or where the child is accommodated if this is unclear - when a child has been, or will be, accommodated by the CCG for three months or more (e.g. in hospital). This is so that the local authority can assess the child's needs and decide whether services are required under the Children Act 1989.

A referral to Children's Social Care should be explicitly considered for any child admitted to hospital following an episode of deliberate self harm - see the Making a Referral to Children's Social Care Procedure.

When children are in hospital and there are concerns about their welfare if they are discharged then the protocol described in the flow charts - to follow should be followed.

**Hospital Discharge Arrangements**

Where abuse is alleged, suspected or confirmed and children have been admitted to hospital they should not be discharged until:

Children's Social Care has been notified initially by telephone of the Child Protection Concerns;

Written confirmation of the nature of concerns is provided within 24 hours;

A Strategy Discussion (usually in the form of a meeting) is held which includes relevant hospital staff in order to ensure that the professionals involved are clear in respect of the Discharge Plan.

It is the responsibility of Children's Social Care to undertake a Assessment to ascertain whether it is safe for the child to return home and to assess the support required to ensure that the child/young person's welfare is safeguarded following discharge. Such an assessment and decision making should involve discussion with the child/young person. If a decision is taken that this is not appropriate or possible the reason for this decision should be recorded on the child/young person's file and explained to other professionals.

If it is not safe for the child/young person to be discharged from hospital, consideration should be given to reasonable steps being taken to ensure that the child's removal from hospital is prevented until support can be in place and a full Assessment/Enquiry completed.

**Category A Cases (Child Protection Cases)**

This category will include:

Actual non- accidental injuries;

Serious health concerns of presentation; or

Repeated presentations that are considered to be fabricated illness;

Significant injuries where there are serious doubts about the explanation or inconsistent explanations;

Actual sexual abuse;

Mental health/disability; or

Drug/alcohol abuse having an immediate and significant impact on the child or the parent's ability to parent adequately;

Evidence of domestic violence;

The death of sibling under suspicious circumstances.

**Category B Cases (High Level Concerns)**

This category will include:

Unusual inappropriate behaviour of parent/carer;

Unexplained delay in seeking medical attention for significant injuries;

Serious or repeated weight loss;

Failure to thrive without medical reason;

Previous child protection registration/strategy meeting in respect of a child in the family;

Serious concerns about drug or alcohol misuse;

Suspicion of sexual abuse;

Serious concerns about home conditions;

Suspicion of domestic violence;

Serious concerns about a parent's reluctance or inability to cope with a child with disabilities;

Significant mental health of child/parent.

**Category C Cases (Children in Need)**

This category will include:

Frequent visits to the GP;

Number of child or sibling A & E attendance's in last 12 months;

Non-suspicious death of a sibling;

Not registered with a GP;

A display of fear or apprehension when partner/carer visits;

Parental ability to cope;

Concerns Child/YP's drug or alcohol misuse;

Concerns parent's drug or alcohol misuse where it may affect their children;

History of repeated separation of parents/partners/carers;

Frequent change of address;

Concerns about a parent's reluctance or inability to cope with a child with disabilities;

Parent's reluctance to visit child in hospital;

Concerns about the mental health/disability of the parent;

Aggression or violence on the ward (Immediate internal response).

**International Cross-Border Child Protection Cases Under the 1996 Hague Convention**

**Introduction**

The 1996 Hague Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-operation in Respect of Parental Responsibility and Measures for the Protection of Children (‘the Hague Convention’) (implemented in the UK on 1 November 2012) provides an agreed set of legal provisions and cooperation arrangements to cover the handling of cross-border cases where children’s safety or welfare may be an issue.

Non-statutory advice from the Department for Education: The 1996 Hague Convention - Departmental Advice is designed to help local authorities when dealing with cross-border child protection cases.

The advice sets out the key steps that local authorities can take to:

Ask for help or essential information from authorities abroad when dealing, for example, with a child from this country who is in need of support or protection; and

Respond to similar requests put to them by authorities abroad.

**Key Points**

The Convention applies to situations where contracting states need to cooperate over child protection and welfare cases when there is an international dimension. This can include Care Proceedings, contact cases and foster placements abroad.

The aim of the Convention is to bring about better co-operation between countries so that the handling of cases and protections put in place is more efficient, avoids delays and delivers better outcomes for the children involved;

This advice is distinct from Department guidance that already exists on the other main types of cross-border cases – inter-country adoption and child abduction;

The Convention’s provisions do not mean major change for local authorities – in a number of respects they mirror arrangements already in place governing co-operation arrangements between EU member states on these types of children’s cases;

The Convention does, however, extend these arrangements in some situations, and will mean that similar co-operation processes will now also apply between this country and countries outside the EU which have implemented the Convention. It will not apply between England and the other jurisdictions of the UK.

Under the Convention, contracting states can ask each other for information or other types of help when a child’s welfare or protection is at issue.

The different types of requests include, for example:

Asking for another state’s help in tracing a child;

Asking for a report on a child habitually resident in another contracting state;

Asking another state to take measures to protect a child’s welfare;

Seeking the agreement of another state for a child to be placed there in foster or residential care; and

Asking for the transfer of jurisdiction for a child from his/her home state, enabling an authority to make decisions about a child’s welfare if it feels it is best placed to do so.

Local authorities may also be asked by a parent to consider preparing a report on their suitability to have contact with a child living in another state.

Under the Convention contracting states can ask each other for information or other types of help when a child’s welfare or protection is at issue.

A list of the countries that have implemented the Convention (referred to as ‘contracting states’) can be found on the Hague Conference for Private International Law website. In this list only those States which have ‘Entered into Force’ (EIF) are operating the Convention.

**The Central Authority**

Each country is required to establish a Central Authority to help ensure effective communication between child welfare authorities in contracting states. For England the day-to-day administration of the Central Authority's role will be carried out by the International Child Abduction and Contact Unit (ICACU) which is co-located in the office of Official Solicitor and Public Trustee.

Certain types of request have to be made via Central Authorities, while in some cases local authorities can deal directly with their counterparts abroad. It is recommended, however, that local authorities consult ICACU in the first instance for advice about the most appropriate way to make their request. The Central Authority holds useful information about authorities in other countries, and has a wealth of practical experience of cross-border cooperation on child protection cases.

The English Central Authority also monitors the volume and effectiveness of cases handled under the Convention. If local authorities decide to deal directly with their counterparts in other contracting states it is recommended that they notify the Central Authority so they can build as complete a picture as possible of the work arising from the Convention.

There are other agencies too that can offer practical advice, direct services and support on handling cross-border cases. These include:

Children and Families Across Borders (CFAB). CFAB runs a national advice line on inter-country casework (funded by the DfE);

Africans Unite Against Child Abuse (AFRUCA).

Although the Regulations that support the Convention place a duty on local authorities to respond in a timely way to certain types of request, there is no prescription as to the form that responses should take. As far as possible, authorities should follow their existing local procedures, based on a proportionate response to the level of risk of harm to the child.

Local authorities are encouraged to agree a first point of contact to manage any communications between the Central Authority and relevant frontline staff and to let the Central Authority know the contact details. The nominated person should be of sufficient seniority to make decisions on action for international cases, and there should be cover to ensure that urgent requests can be dealt with promptly.

**Making Requests for Information or Action**

The Convention enables a local authority to:

Ask another state to provide a report/information to inform decisions on whether child protection measures should be taken;

Take action to protect a child at immediate risk of harm, even if the child is usually resident in another contracting state;

Ask another contracting state to transfer jurisdiction for a child if a local authority feels it is better placed to make decisions about his/her welfare, or ask another state to take on jurisdiction in the reverse situation;

Consult with the relevant authority in another state about placing a child in foster or residential care in that state;

Ask for help in tracing a child in a contracting state when a local authority is concerned about his/her welfare;

Ask another state to consider taking measures to protect a child who lives in that state;

Provide a report to support a parent’s case for contact with a child living in another contracting state.

**Requesting Information on the Need for Protective Measures**

If a local authority is considering action to protect or safeguard a child, it can ask a competent authority in another contracting state to communicate information it holds that is relevant to the case, regardless of where the child is habitually resident.

If a local authority has welfare concerns about a child who is temporarily living in or visiting their area, it can ask the child’s main country of residence for a report on his/her situation – see Chart 1 -requesting a report to support decisions on the need for child protection measures for the recommended process for this.

The authority in the contracting state is not formally obliged to provide this report. If a local authority has difficulty in getting the information it needs, the English Central Authority may be able to help through liaison with the other state’s Central Authority.

A contracting state can specify that these requests for information must be routed through their Central Authority. You can check whether the country you need to approach has specified this by checking the ‘Reservations/Declarations’ column for that country in the Hague Convention Status Table, available at the Hague Conference for Private International Law website.

**Taking Action when a Child Usually Lives in Another State**

If a local authority identifies a child in need of immediate protection, it must exercise its duties to safeguard and promote the welfare of that child under the Children Act 1989. In urgent cases the Convention provides the local authority with the jurisdiction to take any necessary steps to protect the child until the authorities in the state where the child is habitually resident have taken any necessary action. The presence of an international element to the case should not delay the necessary protective measures.

If the child is only temporarily present in England, the child’s home country will have jurisdiction, and the appropriate authority there is responsible for decisions about the child’s welfare and protection beyond the immediate measures taken (unless a transfer of jurisdiction is sought – see Section 7, Transferring Jurisdiction).

Once steps have been taken to protect the child, the local authority should contact the relevant authority in the child’s home country to inform them of the action taken, ask for information about the child’s circumstances, and agree what further action is needed. Chart 2 - Taking action for a child at immediate risk sets out the recommended process for such cases.

An initial approach to the English Central Authority is recommended, although in these cases contact can be via Central Authorities, or directly to the local authority’s equivalent in the other state. The Central Authority of the other state should be able to provide information on the child protection procedures in that state and may be able to supply the contact details for the appropriate equivalent authority.

If the child needs continuing protection while the local authority is liaising with authority in the other state, the Parental Responsibility and Measures for the Protection of Children (International Obligations) (England and Wales and Northern Ireland) Regulations 2010 allow for an application for an Interim Care Order or Interim Supervision Order, even though it is anticipated that another state will take over jurisdiction before a final order is required.

**Transferring Jurisdiction**

A local authority can seek a transfer of jurisdiction for a child who is habitually resident in another state if it feels it is better placed to make decisions about that child’s welfare. This is done via an application to the High Court, who will then make the request to the child’s home country if appropriate.

The authority in the child’s home country may itself ask for jurisdiction to be transferred to the English local authority. The Central Authority in England aims to keep a record of transfers of jurisdiction, and local authorities are therefore asked to notify ICACU when such arrangements are made.

**Placing a Child Living in England in Foster/Residential Care**

The types of situation that this part of the Convention apply to include those where:

A local authority feels that the most appropriate placement for a child is with family or other Connected Persons in another state;

A child’s foster carer may want to move abroad and the local authority considers it in the child’s best interests to stay with that carer; and

Where a child may need placement in a specialist residential unit in another country.

If a local authority wants to make arrangements for a child in their care (i.e. one subject to a Care Order or Interim Care Order) to live outside England and Wales, it must make an application to court for leave to place the child outside their jurisdiction in accordance with the Children Act 1989 Schedule 2 paragraph 19. If the child is Accommodated under section 20 the Court’s leave is not required, but the authority must obtain the consent of every person with Parental Responsibility for the child before placing the child outside of this jurisdiction.

Under the Convention, a local authority considering this type of placement must consult the relevant authority in the other state, and a placement cannot be made unless consent is given by this authority. This is one of the areas however where there is a practical difference between the application of the Hague 1996 Convention and the EU Council Regulation known as Brussels IIa. If local authorities are considering a placement in a country that is a Member State of the EU, they must do so under Brussels IIa. Placement to another Member State requires their consent only if the law of that state requires public authority intervention for the type of placement concerned.

Where consultation is required, the local authority must provide a report on the child and the reasons for the proposed placement. The Child’s Permanence Report, Foster Carer’s assessment report or any matching report would contain adequate information for this purpose - there should be no need to create a new report form. The Convention allows for requests to be made either via the Central Authority of the proposed state of placement or to a competent authority. It is recommended however that local authorities route these requests through the English Central Authority who will then liaise with the Central Authority in the other state. Chart 3 - Placing a child currently living in England in foster of residential care in another contracting state sets out the recommended process for making this type of request.

If the child is the subject of court proceedings the court may approach the authority in the other state for permission to place the child. If the court sends the request directly to the Central Authority or competent authority in the other state, it must also send a copy of the request to the Central Authority for England.

The local authority must also satisfy the requirements of Regulation 12 of the Care Planning, Placement and Case Review (England) Regulations 2010 in placing a child in care outside England and Wales, ensuring that adequate arrangements are in place for supervising and reviewing the placement. See the Placements Outside England and Wales Procedure in your Children's Social Care procedures manual:

Blackburn with Darwen Children's Services Procedures;

Blackpool Social Work and Safeguarding Service Procedures;

Lancashire Children's Social Care Procedures.

This part of the Convention does not apply to:

Adoptive placements (these are governed by the 1993 Hague Convention on Inter country Adoption);

Placements which are private family arrangements; or

Placements of children under Special Guardianship Orders – these are private law orders and do not constitute a placement by a local authority.

It will however apply to placements of a child in care for assessment in a possible adoptive placement. If a placement of this sort is contemplated the local authority should seek legal advice.

**Asking Another State to Trace a Child**

If a local authority has taken steps to safeguard a child’s welfare (or plans to do so) and believes that he/she has been taken out of the local authority area to another contracting state, the Convention enables the local authority to ask another contracting state for help in determining the child’s location. Chart 4 - asking a central authority in another state to locate a child describes the process for this type of request.

These requests should be made to the Central Authority of the state to which it is believed the child has moved, but it is recommended that this is done via the English Central Authority. The requests should be accompanied by an explanation of the child’s circumstances and any information which might assist the other state in tracing the child’s address.

If the child is habitually resident in England and court proceedings are started or ongoing, the court can request the authorities in the other state to assume jurisdiction over the child if they appear better placed to do so.

If there are serious concerns about a child suffering Significant Harm and this child is moved into another state, the local authority must inform the relevant authorities of that other state of the danger to that child and also of any measures they were taking or considering to protect the child.

**Asking Another State to Protect a Child Living in that State**

The Convention enables a local authority to ask another contracting state to consider the need to protect a child from harm who is habitually resident in that state. Local authorities should provide sufficient information for the authority in the other state to make a decision. This request can be made via the English Central Authority or directly to the Central Authority in the other state. The Central Authority in that state can ask its competent authority to consider the need to take protective measures, but the authority is not obliged to do so.

**Providing a Report to Support Parents Contacting a Child**

If a parent in England is seeking by court proceedings to obtain or maintain contact with a child living in another contracting state, he/she can ask their local authority to prepare a report on their suitability to have this contact for submission as evidence to the authorities in the other state.

There is no duty on an English local authority to agree to prepare such a report or provide any information. However local authorities must exercise their discretion reasonably and cannot have a blanket policy of refusing to prepare such reports.

If a local authority agrees to this request, it can gather information about the parent’s suitability to have contact with the child and about any conditions that it thinks it would be appropriate for the overseas court to impose. The court or authority dealing with the application for contact in the child’s home state must consider the local authority’s report before making their decision.

A local authority may charge a ‘reasonable’ fee for providing this service. This means a charge that is as close as possible to the actual costs of providing that service, including indirect costs (for example a proportion of the on costs). Local Authorities will need to include their charging scheme, if any, as part of their policy on providing this service.

A local authority may provide a service under this Article by subcontracting the work to another agency.

**Handling Requests from Other Contacting States**

Just as local authorities in this country can ask for certain types of help or information from other contracting states, other contracting states can ask for a similar range of help from our authorities.

Handling a request for information on a child’s situation

A local authority may be asked for information about a child by a competent authority in another contracting state that is considering protection measures for that child, regardless of where the child usually lives. These types of request to an English local authority should be routed through the English Central Authority.

If a child is habitually resident and present in England, an authority of another contracting state with which the child has a substantial connection may ask the English Central Authority to provide a report on the child’s situation. If the Central Authority thinks that it is appropriate to do so, it will pass the request on to the local authority which must provide a report as soon as reasonably practicable.

The implementing Regulations for the Convention allow local authorities to supply relevant information lawfully, providing that doing so would not put the child or their property at risk, or threaten the life or liberty of a member of the child’s family. Further advice on information sharing can be found in the Question and Answer Section of the 1996 Hague Convention Advice DfE website.

There is no prescribed format for responding to these requests. A letter may be enough, or if a more detailed report is required, a format similar to those used to respond to Court requests for reports under section 7 (a welfare report) or section 37 (Court direction to investigate child’s circumstances and consider whether to apply for a Care or Supervision Order) of the Children Act 1989 would be appropriate.

On occasions the local authority approach for this type of information may be made to CAFCASS – for example, in situations where Cafcass has been involved with the child or the family in other court proceedings.

Chart 5 - Handling a request for a report/information on a child's situation sets out the recommended process for handling this type of request.

**Handling requests to transfer jurisdiction for a child**

An authority in another contracting state can seek a transfer of jurisdiction for a child if it feels that it is better placed to assess the child’s best interests.

The other contracting state will need to make an application to the High Court for transfer of jurisdiction, unless the child is already the subject of court proceedings. In this case the court dealing with the matter will need to transfer the request to the High Court for consideration.

12.3 Request from another state for foster care or home transfer

An authority in another contracting state can only place a child in foster care or a residential unit in England if the competent authority has consented to the placement.

This restriction applies to a placement of a child for whom the authority of another state is responsible. It does not apply to placements for adoption as these are governed by the 1993 Hague Convention on Inter-country Adoption.

In England, the competent authority for these purposes is the local authority with responsibility for children’s services in the area where the contracting state proposes to place the child.

In many cases, the child will not be the subject of any proceedings here. The authority in the contracting state must provide the English local authority with a report about the child and the reasons why the placement is being considered. The relevant local authority should deal with the placement request as quickly as possible.

Before consenting to the placement, the local authority, acting as the competent authority, will need to make its own independent assessment of whether the proposed placement is appropriate in the best interests of the child and provides him or her with the same safeguards as a comparable arrangement for the placement of an English child.

For example the authority may wish to consider such issues as:

Whether based on the information provided about the child’s needs the placement for the child appears to be appropriate;

The frequency and suitability of arrangements for keeping the plan under review;

Arrangements for family contact (if appropriate);

Whether the plan has taken the wishes and feelings of the child into account and allows for the child to have access for support should they wish; and

The planned duration of placement and aftercare arrangements.

Should a local authority, (acting as a competent authority), not have sufficient information to be able to give informed consent that confirms that the proposed placement is appropriate for the child concerned, it may seek further information from the authority in the contracting state wishing to make the placement.

The competent authority will be entitled to refuse consent. For example, following scrutiny of information, the authority could come to the view that the proposed placement is unsuitable for the individual child – perhaps because arrangements for review of the plan or for aftercare are not suitable; or because the authority is concerned about the quality of the proposed placement indicating its unsuitability, because of other information in its possession about the care and safety of other children placed there.

If the local authority controls, manages or has some other interest in the institution at which the child is proposed to be placed, the local authority must ensure that the decision as regards consent is made autonomously from its involvement in running the institution.

If the local authority agrees to the placement, the legal framework under which the child will be placed should be established. The two authorities should agree the responsibility for monitoring and review of the placement. Such monitoring and review arrangements must be compatible with the equivalent arrangements for placing English children in comparable placements. See the Looked After Reviews Procedure in your Children’s Social Care procedures manual:

Blackburn with Darwen Children's Services Procedures;

Blackpool Social Work and Safeguarding Service Procedures;

Lancashire Children's Social Care Procedures.

Where the child is to be placed with a foster carer, the local authority should establish whether the legal structure of the placement gives the carer Parental Responsibility. If it does not, regardless of any agreement between the authorities, the local authority will have responsibility to monitor the placement as a Private Fostering arrangement.

If the child is the subject of any court proceedings in England and Wales the competent authority to make the decision is the court, which will fix a directions hearing to consider the request.

**Requests to locate a child believed to be in the LA area**

If an authority in a contracting state is concerned that a child needs protection and believes the child has been removed from their area and taken to England, they may request assistance from the English Central Authority in tracing that child. Chart 6 - Request to locate a child believed to be in the local authority area sets out the recommended process for handling these requests.

Local authorities have a duty to assist with these requests. It is suggested that the starting point should be the usual local authority procedure for tracing a child missing from care or education. If initial checks of any relevant databases do not trace the child, local authorities can decide what level of further checking is proportionate to the risk factors described by the requesting authority.

If the risk of harm to a child is significant and there is a credible reason to believe that the child is in the local authority’s area, it may be proportionate to share information with other professionals, including community and voluntary agencies.

If an address is found for the child, the local authority should consider whether disclosing this information will pose a risk of harm to the child or his family, or be a criminal offence or contempt of court. Local authorities can withhold information in these circumstances. If in contempt of court cases the local authority feels it is in the child’s interests to disclose information, they must seek the court’s leave to do so.

**Handling requests to protect a child living in the LA area**

If a Central or other authority in a contracting state has concerns about the welfare of a child habitually resident and present in England, it can ask the relevant local authority to take measures to protect that child. The request needs to be made with supporting reasons to the Central Authority in England, who may pass the request on to the local authority.

**Intra-familial child sexual abuse**

Refers to child sexual abuse (CSA) that occurs within a family environment. Perpetrators may or may not be related to the child. The key consideration is whether the abuser feels like family from the child’s point of view.

Around two-thirds of all CSA reported to the police is perpetrated by a family member or someone close to the child.

Where research has recorded the gender of perpetrators of intra-familial CSA, the vast majority have been found to be male, although abuse by women does occur. In around a quarter of cases, the perpetrator is under 18.

CSA in the family is rarely an isolated occurrence and may go on for many years.

Much abuse in the family remains undisclosed. Children may fear their abuser, not want their abuser to get into trouble, feel that the abuse was ‘their fault’, and feel responsible for what will happen to their family if they tell. Disabled children and some black, Asian and minority ethnic children face additional barriers.

Abuse by a family member may be particularly traumatic because it involves high levels of betrayal, stigma and secrecy.

CSA in the family is linked to a range of negative outcomes over the whole of the life course, including poorer physical and mental health, lower income, relationship difficulties and further violence and abuse.

However, not all survivors experience long-term impacts. Much depends on the nature and duration of the abuse, the individual’s coping mechanisms, and the support they receive. Supportive responses from non-abusing carers are particularly important.

Effective support is critical to enable disclosure, and during investigation and legal proceedings. Therapeutic support for young people can have a positive impact but the availability of services remains piecemeal.

Both adult survivors and children/young people value services that listen to, believe and respect them; where professionals are trustworthy, authentic, optimistic and encouraging, show care and compassion, facilitate choice, control and safety, and provide advocacy.

It is important to provide support to the whole family, and particularly to non-abusing parents, following abuse.

**What is intra-familial CSA?**

The UK Government’s definition of CSA for England is:

…forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.  (ref: [Working Together to Safeguard Children 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf#page=93)).

There is no single agreed definition of intra-familial CSA. However, it is generally recognised that, in addition to abuse by a relative (such as a parent, sibling or uncle), it may include abuse by someone close to the child in other ways (such as a step-parent, a close family friend or a babysitter). This understanding is in accordance with Crown Prosecution Service guidelines on the Sexual Offences Act 2003, which state:

These offences reflect the modern family unit and take account of situations where someone is living within the same household as a child and assuming a position of trust or authority over that child, as well as relationships defined by blood ties, adoption, fostering, marriage or living together as partners.

In thinking about whether abuse is intra-familial, perhaps the most important question for professionals to consider is: ‘Did this perpetrator feel like family to the child?’

**The prevalence of intra-familial CSA**

It is difficult to be certain about how much CSA happens. Estimates vary widely according to how studies define abuse and the methods used, with most based on retrospective reports by adults. Studies suggest that 15–20% of girls and 7–8% of boys experience some form of sexual abuse before the age of 16. In a UK study involving almost 2,000 young people aged 18–24, nearly 11% reported some kind of unwanted sexual experience, and 6% reported coerced sexual acts, when they were under the age of 18. It is estimated that CSA in the family environment comprises up to two-thirds of all CSA reported to the police.

The majority of known CSA is perpetrated by people known to the child, and the most serious forms of abuse are more likely to involve abusers who are family, friends or acquaintances. The vast majority of identified perpetrators of CSA, including abuse in the family, are male, although abuse by women does occur. Crime survey data indicates that 4% of sexual assaults on under-16s by adults are committed by fathers, 5% by stepfathers and 1% by mothers; other family members (gender unspecified) commit 16% of such assaults. Additionally, it is estimated that a quarter of all cases of CSA in the family environment involves a perpetrator under the age of 18.

Intra-familial CSA can involve all kinds of contact and non-contact abuse, including online-facilitated CSA. However, there is limited research into how or with what frequency abusers use technology within the family.

Abuse in the family generally starts at a younger age than extra-familial CSA, and may continue over many years.

CSA occurs in all kinds of families and across all races and ethnicities, although there are differences in the extent to which abuse gets reported and responded to. High levels of secrecy, shame and stigma within some black, Asian and minority ethnic (BAME) groups, combined with cultural assumptions by professionals can increase barriers to disclosure. BAME children are under-represented in child protection services when it comes to sexual abuse.

Research indicates that disabled children are more than three times more likely than non-disabled children to be victims of CSA. Disabled children are often more dependent on their caregivers, may have more limited means of communication and may be less likely to be perceived as potential victims. These factors, combined with a lack of specialised professional knowledge, can lead to low levels of disclosure and inadequate responses.

Although most research relates to sexual abuse perpetrated by individual family members, families can also be involved in the organised abuse of children involving multiple perpetrators or child sexual exploitation.

**The identification of intra-familial CSA**

One of the difficulties in estimating prevalence is that so much sexual abuse remains unidentified. It is estimated that only one in eight victims of CSA in the family environment comes to the attention of statutory authorities. Disclosure by children is rare, so professionals and other responsible adults need to be able to spot the signs of possible abuse and take appropriate action.

The reasons children keep silent include fear of their abuser, not wanting their abuser to get into trouble, feeling that the abuse was ‘their fault’, and feeling responsible for what will happen to their family if they tell. Children recognise the importance of telling but believe that most children in their position would not feel able to disclose. In addition, many child victims do not recognise that they are being abused until much later, often when they are adults.

Many children do not ‘tell’ in a straightforward way; rather, their behaviour and demeanour or the characteristics or behaviour of caregivers indicates that something is wrong. Those who do tell are not always heard or believed, and, as noted above, some groups of children such as disabled children and BAME children face greater barriers to disclosure. Children abused by a female family member can face higher levels of disbelief from professionals, who may also minimise the seriousness of such abuse.

Important facilitators that enable children to tell include having access to safe adults with the skills to listen, and having the opportunity to obtain information and confidentially explore the consequences of disclosure.

**The impacts of CSA by family members**

The complex relationship between sexual abuse and other aspects of a person’s life means it is not usually possible to say that an outcome has been caused by their experience of CSA. Factors which may influence the impact of abuse include its severity and duration, the age at which it occurred, the relationship between victim and perpetrator and other difficulties and supports in a child’s life. There is currently no research that differentiates impact of intra-familial abuse by gender of abuser or victim.

An influential model proposed four likely impacts of CSA:

1. Traumatic sexualisation (where sexuality, sexual feelings and attitudes develop inappropriately).
2. A sense of betrayal (because of harm caused by someone the child vitally depended upon).
3. A sense of powerlessness (because the child’s will is constantly contravened).
4. Stigmatisation (where shame or guilt are reinforced and become part of the child’s self-image).

To these can be added secrecy (including the fear and isolation this creates) and confusion (because the child is involved in behaviour that feels wrong but has been instigated by trusted adults). While these impacts are not unique to intra-familial CSA, their combination and intensity in this context makes the experience particularly damaging.

CSA is strongly associated with the following adverse outcomes across the life course:

* physical health problems, including immediate impacts and long-term illness and disability
* poor mental health and wellbeing
* externalising behaviours such as substance misuse, ‘risky’ sexual behaviours, and offending
* difficulties in interpersonal relationships
* socio-economic impacts, including lower levels of education and income
* vulnerability to revictimisation, both as a child and as an adult.

However, not every child who experiences sexual abuse suffers serious consequences. The poorest outcomes tend to be for children whose sexual abuse is combined with other adversities (such as bereavement) and/or other forms of maltreatment, and recent research suggests that it is the accumulation of victimisation across the life course that has the most negative effects.

A number of factors may contribute to an individual’s resilience to the impacts of CSA, both at the time of the abuse and later in life. These factors include high self-esteem or self-reliance, the development of positive coping strategies and the informal support a child receives from adults in their life, or through school, religious groups or social clubs.

**Effective responses to CSA in the family**

Adult survivors and children value services that listen to, believe and respect them. There are often higher levels of satisfaction with services provided by the voluntary sector – including rape crisis centres, counselling services and independent sexual violence advisors – than with statutory services such as police, hospitals and social care.

Many children who experience CSA in the family receive no support because the abuse remains undisclosed. If a disclosure occurs, professional responses and the availability of services can vary widely. While children and young people highlight the importance of being supported in the aftermath of disclosure, their experiences suggest that services often fail to support them through difficult child protection and legal processes. Children value support from professionals who are trustworthy, authentic, optimistic and encouraging; show care and compassion; facilitate choice, control and safety; and provide advocacy.

**Child protection responses**

The number of children on child protection plans because of sexual abuse has fallen dramatically over the past 20 years: it is now the lowest category of registration, far below those for neglect and emotional abuse. There are also considerable regional variations. There is no research to explain these trends, but we can be fairly certain that they have not happened because of a reduction in incidence. Indeed, over the same period, the police have recorded a large increase in the number of crimes involving CSA.

The child protection statistics may reflect changing trends in priorities, with some forms of CSA slipping down the agenda as local authorities and partner agencies have focused specifically on child sexual exploitation and prioritised other issues such as the impact of domestic violence on children. It may also reflect professional/organisational anxieties about sexual abuse in the family: the challenges of obtaining a disclosure, overcoming denial and finding ways of protecting children in a complex family context can engender feelings of professional helplessness.

Overcoming these challenges requires confident professionals, able to undertake direct work with children, and a supportive child protection system rather than one that is bureaucratic and target-centred. Recent innovations seeking to achieve such change have highlighted the importance of social workers combining empathy and collaboration with purpose and authority, good reflective supervision, access to expertise, and the use of multi-disciplinary teams including adult specialists in mental health or domestic abuse working alongside children’s practitioners.

**Criminal justice interventions**

Despite increased reporting and investigation of CSA, relatively few cases reach the Crown Prosecution Service, and even fewer get to court. One factor is the failure to follow good practice guidance on Achieving Best Evidence interviews, which are crucial in the absence of physical and other corroborative evidence.

Legal processes may also retraumatise victims. When cases do reach court, there are long delays in waiting for trial, low use of special measures to help children give best evidence and aggressive cross-examination techniques. To protect the interests of children, as well as secure convictions, a more child-friendly and responsive system is needed.

**Therapeutic support**

Therapeutic support for children and young people who have experienced abuse in the family may be provided by statutory, voluntary and private sector agencies. However, there is a shortage of such services, and provision varies widely between areas.

Research into the effectiveness of therapeutic support for children following CSA has reported mixed results. A systematic review concluded that cognitive behavioural therapy (CBT) may have a positive impact on depression, post-traumatic stress disorder and anxiety symptoms, although most results were not statistically significant. A similar review of psychotherapy was inconclusive, although one randomised trial in the UK found that group and individual psychotherapy for sexually abused girls was effective – particularly in relation to post-traumatic stress.

A recent randomised control trial in the UK (the largest yet conducted of an intervention for CSA) was an evaluation of the NSPCC’s ‘Letting the Future In’ programme, implemented in 20 services in England, Wales and Northern Ireland. At six-month follow-up it found evidence of reduced emotional difficulties and symptoms of severe trauma for children over the age of eight, and children themselves reported greater confidence; reduced self-blame, depression, anxiety and anger; improved sleep patterns; and better understanding of appropriate sexual behaviour.

**Family-focused interventions**

Interventions that focus on the whole family as well as the individual child are important. Children and young people often feel responsible for the distress of their family in the aftermath of sexual abuse, and this can be reduced through providing support to non-abusing family members.

The disclosure of CSA is a major life crisis for a non-abusing parent, often with long-term effects on their mental health. This can be particularly so if they experienced abuse in childhood themselves. Children are more likely to disclose to their non-abusing parent than to anyone else, and the way a non-offending parent responds to the disclosure of their child’s abuse is crucial, with good support from parents linked to better adjustment in children. Some researchers conclude that the support needs of non-abusing carers are therefore inseparable from those of their child, and their distress should not be overlooked by professionals.

Findings from trials of trauma-focused CBT point to the importance of carer involvement and education in achieving positive outcomes for children and in reducing carers’ stress. A review of 56 systematic reviews identified strong evidence that CBT for non-abusing parents and school-age children is effective in preventing deterioration of child mental health and/or recurrence of abuse. However, even more modest parent-focused interventions (including instructional videotapes based on social learning theory) provided to a parent at the time of a sexual abuse disclosure appeared to have benefits for parents and children.

Parents value parent support groups, particularly those combining support with information about the dynamics and impacts of abuse and practical advice on how to deal with children’s feelings and behaviours. Parents who have participated in such groups report increased wellbeing and confidence, reduced stress, and greater ability to care for their child and deal with professionals. Groups help participants build vital social networks with others who share similar experiences, help to normalise children’s behaviour, and may reduce depression.

**Learning Difficulties and Disabilities of a Parent/Carer**

**Introduction**

Where a parent has a learning disability it is important not to generalise or make assumptions about their parental capacity. Learning disabled parents may need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly needed where they experience additional stressors such as having a disabled child, domestic violence, poor physical and mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. It is these additional stressors, when combined with a learning disability, that are most likely to lead to concerns about the care a child or children may receive.

**Risk to Children**

Children of parents with Learning Difficulties and Disabilities are at increased risk from inherited learning disability and are more vulnerable to psychiatric disorders and behavioural problems. From an early age, children may assume the responsibility of looking after their parent, and in many cases other siblings, one or more of whom may be learning disabled. Unless parents with Learning Difficulties and Disabilities are comprehensively supported - e.g. by a capable non-abusive relative, such as their own parent or partner - their children's health and development may be impaired. A further risk of harm to children arises because mothers with Learning Difficulties and Disabilities may be attractive targets for men who wish to gain access to children for the purpose of sexually abusing them.

**Action to Safeguard**

If any worker has concerns about a child whose parents have Learning Difficulties and Disabilities, A Early Help Assessment should always be undertaken and consideration given to making a referral to Children's Social Care where appropriate. Where a child is considered to be at risk of Significant Harm, a referral must be made using the Making a Referral to Children's Social Care Procedure.

A comparative study of children and families with learning disabled parents referred to Children's Social Care showed twice as many children had severe developmental needs, and five times as many had parents who were experiencing severe difficulties in meeting their children's needs. The research found that parents with Learning Difficulties and Disabilities are more likely to need long-term support.

A comparative study of methods of supporting parents with Learning Difficulties and Disabilities found that group education, combined with home-based support, increases parenting capacity. In some areas, services provide accessible information, advocacy, peer support, multi-agency and multi-disciplinary assessments, and on-going home-based and other support. This 'parenting with support' appears to yield good results for both parents and children.

A specialist assessment is often needed and is recommended. Where specialist assessments have not been carried out and/or learning disability support services have not been involved, evidence from inspections has shown that crucial decisions could be made on inadequate information.

Adult learning disability services, particularly community nurses, can provide valuable input to core assessments, and there are also validated assessment tools available.

**Licensed Premises**

Holders of premises licences, club certificates and personal licences have a statutory responsibility to promote the protection of children from harm in and in the vicinity of their premises and should consider the need to protect children from sexual exploitation when undertaking licensing functions.

The protection of children from harm requires the proactive involvement (and sometimes training) of licensees, management and staff to ensure that the needs of under 18's are considered and addressed in the day-to-day operation of the premises. Family-friendly premises benefit from a loyal customer base with time and money to spend, but like anybody customers have their own set of needs. Premises that want to profit by catering for families must ensure the way they operate meets the needs of under 18s.

There are premises which will want to provide activities that are not suitable for children and those children and young people will therefore be excluded:

From the area of the premises where the activities take place

From the premises as a whole

At the time the activities take place; or

At all times.

Licensees have a responsibility to ensure that where children are excluded, they do not become victims of crime, disorder, nuisance or poor safety standards originating in the premises and spilling out into the local vicinity.

All licensing applications should be screened by officers from Children's Social Care on behalf of the Local Safeguarding Children Board.

The Portman Group offers substantial advice and suggestions related to steps licensees can undertake which directly relate to promoting the licensing objectives including but not limited to age identification schemes.

**Mental Illness of a Parent or Carer**

**Introduction**

Mental ill health in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family. The parent or carer may neglect their own, or their children's physical, emotional and social needs. The child may take on inappropriate caring responsibilities, which may have an adverse effect on his or her development.

Some forms of mental ill health may blunt parent or carers' emotions and feelings or cause them to behave in bizarre or violent ways towards their children or environment. At the extreme a child may be at risk of severe injury, profound neglect, or even death. A study of 100 reviews of child deaths where abuse or neglect had been a factor in the death, showed clear evidence of parental mental ill health in one third of cases. Post-natal depression can also be linked to both behavioural and physiological problems in the infants of such mothers.

All professionals have a responsibility to safeguard the welfare of children and young people. Remember Think Parent - Think Child - Think Family.

Children may not be exposed to or involved with specific symptoms, yet parenting can still be altered. The presence of mental illness can reduce and/or change a parent's responsiveness toward their child. For example, a parent may become less emotionally involved, less interested, less decisive or more irritable with the child. This will affect the quality of the parent-child relationship, parenting capacity and the child's well-being.

**Risk Indicators**

Significant history of violence and parental non-compliance with services and treatment are risk factors for children. The adverse effects on children of parental mental illness are less likely when parental problems are mild, last only a short time, are not associated with family disharmony, and do not result in the family breaking up. Children may also be protected from harm when the other parent or a family member can help respond to the child's needs. Children most at risk of Significant Harm are those who feature within parental delusions, and children who become targets for parental aggression or rejection, or who are neglected as a result of parental mental illness.

**High Risk Indicators**

A Referral to Children's Social Care (see Making a Referral to Children's Social Care Procedure) must be made where there evidence of:

Delusional beliefs involving any child;

Homicidal thinking involving children prior to completing/ attempting suicide or might harm their child as part of a suicide plan.

Children's Social Care should be consulted and a referral must be considered where there is evidence of:

Psychotic beliefs particularly if involving the child;

Persistent negative views expressed about a child, including rejection ongoing emotional unavailability, unresponsiveness and neglect;

Inability to recognise a child's needs and to maintain appropriate parent-child boundaries;

Ongoing use of a child to meet a parent's own needs;

Distorted, confusing or misleading communications with a child including involvement of the child in the parent's symptoms or abnormal thinking. For example, delusions targeting the child, incorporation into a parent's obsessional cleaning/contamination rituals, or a child kept at home due to excessive parental anxiety or agoraphobia;

Ongoing hostility, aggression, irritability and criticism of the child;

Serious neglect of the child;

Any history of domestic violence.

**Action to Safeguard**

When there is a childcare issue of concern, Health, Children's Social Care and non-statutory sectors should ensure that lines of communication are opened and remain open during the process of referral, assessment, planning and reviews.

Joint assessments should be undertaken between agencies to facilitate assessments and safeguard children, when it is recognised and agreed that it is necessary to do so. The mental health professional involved in the assessment would normally be the care co-ordinator for the Care Programme Approach. If not then outcomes must be fed back to the care co-ordinator.

If a parent or carer is admitted to hospital, a notification must be sent to the paediatric liaison nurse or nearest equivalent. If a referral is made between Children's Social Care and Mental Health Services, a check should be made through the information system as to whether the family member is known to the service. If other workers are involved, they should be informed of the Referral.

Where there is difficulty in accessing agency or professional support the Children's Social Care Mental Health Managers, the Safeguarding Lead should consult with each other on how to proceed with a case if they have concerns.

Requests for and provision of information should be followed up in writing within 5 working days, if not made in writing in the first instance.

Where the Children's Social Care and Adult Mental Health Services are involved with an individual or family, a representative from each service should be invited and should attend standard assessment or Strategy Discussions. The standard meetings and conferences are:

Mental Health - Patient or service user assessment or screening, Hospital Ward meeting, patient discharge meeting, CPA meeting and follow-up CPA Review meetings;

Children's Social Care - Single Assessment Meeting, Strategy Discussion, Initial Child Protection Conferences and Child Protection Review Conferences, Children in Need (Family Support)

Meetings and Reviews;

Early Help – Early Help Assessment Meeting, Reviews.

The whereabouts and any risks must be considered during any leave including Section 17 leave arrangements.

Those working in all agencies should be aware of the designated and named professionals for child protection who can provide advice.

Close collaboration and liaison between adult mental health services and Children's Social Care are essential in the interests of children. This will require sharing information to safeguard children and promote the welfare of children or to protect a child from Significant Harm. See also Information Sharing and Confidentiality Procedure.

Where Child and Adolescent Mental Health Services (CAMHS)are involved in a family and adults are also known to the Adult Mental Health Services, close collaboration should take place between both services.

Information about the child/children in families must be recorded at assessment or as soon as possible and recorded on CPA documentation/client records.

Assessments, CPA monitoring, reviews, and discharge planning arrangements and procedures should prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user, and consider any risks posed to those children.

Risks should also be considered for service users who are not parents but are in contact with children e.g. service users with child siblings or grandchildren.

Children may take on caring roles within the family when a parent is mentally ill. This may include additional chores, caring for siblings and emotional concerns like worrying about the ill parent. Hospitalisation of a parent may lead to changes in roles and/or living circumstances for the family. The impact on children following admission to hospital of a single, socially isolated parent will have quite different implications compared to hospitalisation of a mentally ill adult in a family where good quality alternative carers are available. The specific needs and safety of the children must be assessed directly and not assumed.

Mental Health personnel may also be requested to contribute to Single Assessments led by Children's Social Care.

In addition to the interagency working described above, it is especially important to ensure that Health Visiting and Primary Health Care staff and Children's Social Care are involved in any cases involving mothers being treated for post-natal depression or puerperal psychosis.

Appropriate completion of the Health and Children's Social Care assessment documentation under the CPA should ensure that any childcare issues are highlighted so that a referral to Children's Social Care can be made where appropriate under the Making a Referral to Children's Social Care Procedure. This should be documented and any subsequent childcare responsibilities also documented in the adult's care plan.

**Missing Children and Families**

**Children Who Go Missing**

See also Joint Protocol Children and Young People who Run Away or go Missing from Home or Care.

**Families Who Go Missing**

**Introduction**

Local agencies and professionals, working with children and families where there are outstanding concerns of actual or potential Significant Harm, must bear in mind that non-school attendance, a series of missed appointments, cancelled or abortive home visits, may indicate that the family has moved out of the area to another area within the UK or that the family has moved abroad;

This possibility must also be borne in mind when there are concerns about an unborn child who may be at future risk of Significant Harm;

These procedures apply if a child in the following circumstances goes missing (including where it is suspected that they may have moved abroad) or cannot be traced:

A child who is the subject of a child protection referral or Section 47 Enquiry;

A child who is the subject of a Child Protection Plan who goes missing or is removed from her/his address outside the terms of the Child Protection Plan;

Any child known to a statutory agency who goes missing in circumstances which raise concerns, e.g. where a child is removed from hospital against medical advice and cannot be traced.

These procedures also apply to adults whose whereabouts become unknown in the following circumstances:

A pregnant woman when there are concerns about the welfare of the child following birth;

A family where there are concerns about the welfare of the child because of the presence of an individual who poses a risk of harm;

A parent known to be experiencing domestic abuse.

For children who go missing where there are concerns about forced marriage, see Forced Marriages Procedure.

**Initial Action**

In any of the above circumstances Children's Social Care holding case responsibility must be notified immediately;

The Designated Manager (Children with a Child Protection Plan) must be informed if a child who has a Child Protection Plan goes missing;

Children's Social Care must contact all local agencies who know the child to inform them of the situation and, where the child is the subject of a Child Protection Plan, all members of the Core Group must be informed in writing;

Existing records in these agencies must be checked to obtain any information, which may help to trace the missing child, e.g. details of friends and relatives, and this information should be passed to any Police officer undertaking the missing person enquiry;

The Designated Nurse must be notified about a missing child, family or a pregnant woman. S/he then has responsibility for initiating appropriate local or national notifications of Clinical Commissioning Groups and Hospital Trusts;

The Children Missing from Education Office should notify colleagues in other areas about a student whose name may show up on the roll of a new school. See Children Missing from Education (Blackburn with Darwen local policy);

The social worker must ensure, wherever practicable, that all those with Parental Responsibility are informed that the child is missing;

The social worker must discuss with her/his manager whether to notify members of the extended family and if so, how.

**Strategy Discussion/Meeting**

If the child has not been traced, a Strategy Discussion/Meeting should be convened within a maximum of 5 working days or sooner depending on the level of risk and complexity - see Strategy Discussions Procedure;

Members of the Strategy Discussion/Meeting will need to consider whether to circulate other local authorities and other agencies in the area in which the child and family are thought to have gone;

Consideration should be given to national notification of authorities and agencies including the appropriate Benefits Agencies;

A senior member of Children's Social Care should seek assistance from the Department for Work and Pensions if the Police have not already contacted them;

If there is any suspicion that the child may be removed from UK jurisdiction, appropriate legal interventions should be considered and Legal Services consulted about options. It may also be appropriate to contact the Child Abduction Unit or the Consular Directorate at the Foreign and Commonwealth Office, which may be able to follow up a case through their consular post in the country or countries concerned.

**Follow-up Action by Children's Social Care**

If the Strategy Discussion/Meeting agrees that the details of the child or family are to be circulated to other local authorities, the social worker should draft a short letter giving details of:

The children in the family;

Other family members or significant adults;

The circumstances causing concern;

Action required if a child is found, including any immediate protective action to be taken;

Details of contact arrangements for the social worker - including out of office hours contact;

Where possible physical descriptions of the key people and photographs, if available.

The letter should be sent to the Designated Manager (Children with a Child Protection Plan) for distribution to her/his peers nationally, who in turn should circulate within their own Children's Social Care and local agencies;

If the child is subject to a Child Protection Plan and not found within 20 working days, the Child Protection Review Conference must be brought forward to consider whether any other action should be taken.

**When the Child, Family or Adult is Found**

When a child is found or returns to their home authority, there should, if practicable, be a further Strategy Discussion/Meeting within one working day, attended by previously involved agencies to consider:

Immediate safety issues;

Whether to instigate a Section 47 Enquiry and agree if a single or joint agency enquiry is necessary;

Who will interview the child if a Section 47 Enquiry is to be initiated;

Who will interview the child if a Section 47 Enquiry is not required;

Who needs to be informed of the child's return (locally and nationally).

Any child who is found following a period missing should, regardless of whether s/he is believed to have experienced, or be at risk of, Significant Harm, be offered an interview by a social worker and/or Police officer; where the child requests it, arrangements should be made for the interview to be conducted by an independent person;

If the child indicates a wish to be interviewed by an alternative professional, all reasonable efforts must be made to accommodate the child's wishes;

This interview should provide a safe opportunity for the child to discuss any concerns regarding her/his care, including if they chose to run away from an abusive situation;

When the child is found outside the area of the child's home local authority and is not likely to return, see Transfer Across Local Authority Boundaries Procedure;

If the child is subject to a Child Protection Plan, consideration must be given by the social worker and manager in consultation with the Conference Chair, as to the need to bring forward the next

Child Protection Review Conference.

**Children Missing from Other Local Authorities**

The Designated Manager (Children with a Child Protection Plan) must ensure that a system for keeping and referring to a list of the 'Notifications of children and/or families who are missing' is in place;

If, after 2 years there is no communication from the authority where the child and/or family went missing, the child and/or family's details will be removed from the list.

**Children Who Go Missing from Education**

See also Blackburn with Darwen Procedures and Protocol for Children Missing from or not Receiving a Suitable Education and Blackpool Children Missing From Education.

**Introduction**

Children who go missing from education may also be suffering from Significant Harm as they are no longer in an environment which enables agencies to safeguard and promote their welfare. If it is suspected or becomes apparent that a child is not receiving education the Child Missing Education contact person should be informed;

If a child or young person is receiving an education, not only do they have the opportunity to fulfil their potential, but they are also in an environment that enables local agencies to safeguard and promote their welfare. If a child goes missing from education they could be at risk of Significant Harm;

**Children Likely to Go Missing from Education**

There are a number of reasons why children go missing from education. These can include:

Failing to start appropriate provision, and hence never entering the system;

Ceasing to attend due to exclusion (including illegal and/or unofficial exclusions) or withdrawal;

Failing to complete a transition between providers (e.g. being unable to find a suitable school place after moving to a new local authority area).

Below is a list of children who are likely to go missing from education:

Young people who have committed criminal offences;

Children living in women's refuges;

Children in homeless families, perhaps living in temporary accommodation, houses of multiple occupancy or Bed and Breakfast accommodation;

Young runaways;

Children with long-term medical or emotional health problems;

Unaccompanied Asylum Seekers and refugees, or the children of asylum seeking families;

Looked After children;

Children from Gypsy/Roma/Traveller background;

Young carers;

Children from transient families, i.e. students who have experienced high levels of mobility between different education providers;

Teenage mothers;

Children excluded from school;

Children in Private Fostering arrangements;

Children informally excluded from school and/or those placed on long-term part-time timetables;

Children taken off roll following a lengthy absence due to an extended family holiday taken in term-time;

Children entering or leaving the independent schools sector;

EC nationals who have the right of abode in the UK - this now includes a significant number of asylum seekers granted status by other EC countries and who have subsequently moved to the UK;

Others who have come from abroad to live and/or work in the UK.

**What the Local Authority Does Regarding Children who are Missing from Education**

The local authority and its partners are committed to ensuring that:

There are secure procedures and monitoring systems in place for ensuring that all children aged 0 - 16 are known to health and children's services;

Partner services will bring any children and young people who they support to the attention of the nominated person for Children Missing Education when such children are not attending/accessing education or training;

There are secure arrangements for sharing information when children and young people aged 0 - 16 move across locality areas, including unknown destinations;

This policy recognises the importance of reducing the risk of children missing from education, and it is envisaged that this will be best achieved by establishing, implementing and maintaining:

Awareness raising with the general public regarding our need to know about any children missing from education - this to include publicising details of the local authority's nominated person for Children Missing from Education;

Procedures for making prompt referrals to the Education Welfare Officer - Student Tracking;

Procedures to identify and locate children who go missing from education - through liaison with the other services and agencies who are most likely to come into contact with such children;

Procedures to identify children missing education through liaison with other local authorities and access to national databases, e.g. UK Visas and Immigration;

Maintaining a regularly updated central register of all local children know to be missing from education;

Procedures to re-engage missing children & young people, with appropriate educational provision through a Lead Professional and action planning process;

Maintaining and developing systems for identifying those at risk of becoming Children Missing Education.

**Attendance Strategy**

The attendance strategy defines the different roles and responsibilities of all those concerned in ensuring that children attend school regularly and the actions that may be taken to achieve this. The local authority has also produced an extended-leave policy (covering family holidays taken in term-time) which advises schools on procedures that must be followed if a child fails to return to school by the date agreed with parents/carers.

**Common Transfer Form (CTF)**

The law requires that CTF data is sent to a student's "new" maintained school by the former school within 15 days after the student ceases to be registered at the "old" school;

The unique student number (UPN) needs to be included in the CTF as a unique identifier for the student. If a child's destination is not known, schools are advised not to post the CTF to the 'Lost Student Database' (LPD) without first contacting the education welfare team.

**Admissions and Leavers Database**

All schools are requested to inform the local authority of children who are admitted to their school. They are also required to inform the local authority with details of children who are no longer on roll at their school. The information is shared with local health centres.

**Choice Adviser**

The 'Choice Adviser' supports the local authority's admissions team by offering impartial advice to parents applying for their child's school admission. The parents/carers of children who fail to apply for school place are contacted by the Choice Advisor.

**School Admissions**

The local authority's admissions team is provided with details by both the Council's legal team and the local voluntary aided faith schools of those children whose admission appeals have not been successful. This information and details of those children who fail to attend school either in their reception year group or Year 7 are provided to the local authority's education welfare team;

The local authority also has protocols in place for identifying and reintegrating children permanently excluded, with fair access protocols (formerly known as hard to place students) for managed moves and transfers between schools. The local authority is in the process of developing new mechanisms for identifying Gypsy, Roma and Traveller children who move into the area, so that their suitable education can be secured;

UK Visas and Immigration provides details to the local authority of any asylum seeking families moving into the borough.

**Elective Home Education**

The law allows parents to arrange for their children to be educated at home, rather than at school. The local authority has a robust system in place for monitoring the education of children that are educated at home.

**Independent Schools**

Independent schools are legally required to advise the local authority about the details of all children admitted and removed from the roll of their school. The independent schools are also required to complete a Common Transfer Form.

**Truancy and Beat-Sweep Patrols**

Truancy Sweeps are a joint initiative between the local authority's education welfare service and the Police, and these take the form of a series of locality patrols that are run across the area, with joint teams of Police and education welfare officers approaching children who are on the streets during school hours. They serve to help prevent 'truanting' children from being involved in crime or becoming victims of crime;

During a truancy sweep, children and young people out of school are approached and their basic personal details are taken. Checks are then made regarding educational placements and the young people are then (following an interim assessment of their circumstances and the level of risk) returned to their educational placement or escorted home. In both cases, follow-up contact is made with parents/carers. In addition to identifying children missing from their educational placement, these patrols have also located children not registered at any school.

**Education Welfare Officers (EWOs)**

EWOs will work closely with the local authority's admissions team when dealing with parents of children who have failed to register their children at school. EWOs monitor their particular areas for new families, while home visiting. They follow up enquiries or concerns from members of the public who believe children are being kept away from school;

EWOs will carry out checks on school registers to ensure correct attendance codes are used and students who are absent are known to them and those on approved educational activity are monitored by schools;

If the EWO and the school are unable to contact parents/carers of a child who has been absent for maximum of ten days, they should inform the Principal Education Welfare Officer for consideration of what further enquiries are necessary.

**Government Lost Student Database (s2s)**

The local authority will regularly check the lost student database for children who are missing. It will also respond and send referrals to other local authorities about children missing education.

**Student Referral Unit (PRU)**

The local authority will refer all excluded children requiring admission at the PRU. PRU will retain responsibility for ensuring children's regular attendance and take necessary steps for informing others if children leave the establishment.

**Other Agencies**

Staff from any agencies who come across any children who they believe may not be accessing educational provision are requested to contact the nominated Children Missing Education officer. These may involve Housing Officers, Neighbourhood Wardens, Community Safety Officers, Police etc.

**Modern Slavery (Trafficking)**

**Definition**

Modern slavery is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal gain. Traffickers and slave drivers trick, force and/or persuade children and parents to let them leave their homes. Grooming methods are 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, servitude and inhumane treatment.

Child trafficking or child modern slavery is identified as child abuse which requires a child protection response (see Protection and Action to be Taken). It is an abuse of human rights, and all children, irrespective of their immigration status, are entitled to protection under the law.

Children are recruited, moved or transported and then exploited, forced to work or sold. The Modern Slavery Act 2015 (applicable mostly in England and Wales[1] includes two substantive offences i) human trafficking, and ii) slavery, servitude and forced or compulsory labour.

Children are not considered able to give 'informed 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 to being trafficked is irrelevant and it is not necessary to prove coercion or any other inducement.

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 - e.g. sex trafficking - children can be groomed and sexually abused before being taken to other towns and cities where the sexual exploitation continues. Victims are forced into sexual acts for money, food or a place to stay. Other forms of slavery involve children who are forced to work, criminally exploited and forced into domestic servitude. Victims have been found in brothels or saunas, farms, in factories, nail bars, car washes, hotels and restaurants and commonly are exploited in cannabis cultivation. Criminal exploitation can involve young people as drug carriers, begging and pick-pocketing. Debt bondage (forced to work to pay off debts that realistically they will never be able to), organ harvesting and benefit fraud are other types of modern slavery.

Victims often face more than one type of 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.

Some young people may not be victims of human trafficking but are still victims of modern slavery. Slavery, servitude and forced or compulsory labour may also be present in trafficking cases; however, not every young person who is exploited through forced labour has been trafficked. In all cases, protection and support is available through the National Referral Mechanism (NRM) process (in England and Wales[2]). The NRM is a 'victim identification and support process' for all the different agencies that may be involved (e.g. the Police, Home Office, including Border Force, UK Visas and Immigration, local authorities and voluntary organisations). See Referring a Potential Victim of Modern Slavery to the National Referral Mechanism (NRM).

* Some provisions also concern Northern Ireland and Scotland. Also see the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015 and the Human Trafficking and Exploitation (Scotland) Act 2015
* (In Scotland and Northern Ireland, however, only trafficking cases (rather than all modern slavery cases) are processed through the NRM

**Risk Factors and Vulnerable Circumstances**

Victims may not always be recognised by those who come into contact with them. They may be unwilling to come forward to agencies not seeing themselves as victims, or fearing further reprisals from their abusers.

**Vulnerable circumstances include:**

Poverty, limited opportunities at home, low levels of education, and the effects of war are some of the key drivers that contribute to trafficking of victims;

Poor and displaced families may hand over care of their children to traffickers who promise to provide them with a source of income, education or skills training, but ultimately exploit them;

Wanting to help their families back at home or seeking better futures;

Escaping familial situations of harm and abuse, homelessness or being orphaned;

A lack of equal opportunities, discrimination or marginalisation and social customs such as children being expected to respect and follow the adult in charge. Faith abuse and other specific practices may be used to control the child. A demand for cheap or free labour or a workforce who can be easily controlled and forced into criminal activity;

Unaccompanied, internally displaced children;

Some children may say they are unaccompanied when claiming asylum - the 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;

Former victims of modern slavery or trafficking;

Trafficked children have an increased risk of going missing from care in the UK, with some rejoining those who exploited them in the first place.

**Indicators**

Signs that a child has been trafficked may not be obvious, or children may show signs of multiple forms of 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 seeming 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 of parental permission for the child to travel to the UK or stay with the adult;

Little or no 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, 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 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 is child 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 - see Making a Referral to Children's Social Care Procedure.

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 meet any urgent health needs and arrange emergency medical treatment if appropriate. Local Community Safety Partnerships commission services for victims of modern slavery and should be contacted to identify the relevant services required for victims.

Any agency or individual practitioner or volunteer who has a concern regarding the possible trafficking of a child should immediately make a referral to Children's Social Care. Practitioners should not do anything which would heighten the risk of harm or abduction to the child.

Prompt decisions are needed when the concerns relate to a child who may be trafficked in order to act before the child goes missing (practitioners must be alert that there will be a high risk of the victim going missing from any accommodation due to their pull factors with abusers).

Decision-making following the receipt of a referral will normally follow discussions with the Police, the person making the referral and may involve other professionals and services.

Specific action during the Single Assessment of a child who is possibly trafficked should include:

Seeing and speaking with the child and family members as appropriate - the adult purporting to be the child's parent, sponsor or carer should not be present at interviews with the child, or at meetings to discuss future actions;

Drawing together and analysing information from a range of sources, including relevant information from the country or countries in which the child has lived. All agencies involved should request this information from their counterparts overseas. Information about who to contact can be obtained via the Foreign and Commonwealth Office or the appropriate embassy or consulate in London (see National Contacts);

Checking all documentation held by child, the family, the referrer and other agencies. Copies of all relevant documentation should be taken and together with a photograph of the child be included in the social worker's file.

Even if there are no apparent concerns, child welfare agencies should continue to monitor the situation until the child is appropriately settled.

The Strategy Discussion / Section 47 enquiry should decide whether to conduct a joint interview with the child and, if necessary, with the family or carers. Under no circumstances should the child and their family members or carers be interviewed together.

Professional interpreters, who have been approved and checked, should be used where English is not the child's preferred language. Under no circumstances should the interpreter be the sponsor or another adult purporting to be the parent, guardian or relative.

On completion of a Section 47 Enquiry a multi-agency meeting should be held convened by the social worker, and involving the social worker's manager, the referring agency if appropriate, the Police and other relevant professionals to decide on future action. Further action should not be taken until this meeting has been held and multi-agency agreement obtained to the proposed plan, including the need for a Child Protection Conference and possible Child Protection Plan.

Where it is found that the child is not a member of the family with whom he or she is living and is not related to any other person in this country, consideration should be given to whether the child needs to be moved from the household and/or legal advice sought on making a separate application for immigration status.

Any law enforcement action regarding fraud, trafficking, deception and illegal entry to this country is the remit of the Police and the local authority should assist in any way possible.

Trafficked children may be accommodated by the local authority under Section 20 of the Children Act 1989. The assessment of their needs to inform their Care Plan and should include a risk assessment of how the local authority intends to protect them from any trafficker being able to re-involve the child in exploitative activities. This plan should include plans to prevent the child from going missing and contingency plans to be followed if the child goes missing. Whilst the child is Looked After, residential and foster carers should be vigilant about, for example, waiting cars outside the premises, telephone enquiries etc.

The local authority should continue to share with the Police any information which emerges during the placement of a child who may have been trafficked, concerning potential crimes against the child, risk to other children or relevant immigration matters.

**Trafficked children need:**

Professionals to be informed and competent in matters relating to trafficking and exploitation;

Someone to spend sufficient time with them to build up a level of trust;

Separate interviews - at no stage should adults purporting to be the child's parent, sponsor or carer be present at interviews or at meetings with the child to discuss future action;

Safe placements if children are victims of organised trafficking operations and for their whereabouts to be kept confidential;

Legal advice about their rights and immigration status;

Discretion and caution to be used in tracing their families;

Risk assessments to be made of the danger if he or she is repatriated; and

Where appropriate, accommodation under Section 20 of the Children Act 1989 or an application of an Interim Care Order.

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

Referrals to the NRM for consideration by the competent authority should be made by the local authority for all potential child victims of trafficking and modern slavery, 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: How to Report a Victim of Modern Slavery factsheet.

There is no minimum requirement for justifying a referral into the NRM and 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 Modern Slavery Victims: Referral and Assessment Forms.

The Duty to Notify - Local authorities have a duty to notify the Home Office about any potential victims of Modern Slavery. For children, completing the NRM form is sufficient to satisfy this requirement.

If the child or anyone connected to them is in immediate danger the Police should be contacted as normal.

Practitioners must arrange safe accommodation for the potential victim.

Where there is reason to believe a victim could be a child, the individual must be given the benefit of the doubt and treated as a child until an assessment is carried out. An age assessment should only be carried out if appropriate to do so, and should not cause a delay in referring into the NRM.

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.

It is important that practitioners make careful notes about what is disclosed, as 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. 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) provides free guidance to professionals concerned that a child or young person is a victim of modern slavery.

**Issues and Challenges**

Children who are trafficked outside of the UK may intrinsically be linked to the immigration system. Practitioners should be aware of the risk of harm to the child if the adult is not able to confirm their immigration status, to avoid a potential child trafficking situation being misconstrued as an 'immigration matter' and thus preventing victims from being recognised. It is important that plans for the child's long term safety are linked to their immigration status, in order to fully understand the child's real identity and the reasons for not having identification documents or false documentation.

Modern slavery is often hidden in nature, and goes unnoticed in our communities, with under-reporting a major concern. Practitioners have the challenge of reaching out to a vulnerable and an 'invisible' set of children. As well as assessing the significant harm to the child, there will need to be consideration for other key areas such as organised crime, working with UK Visas and Immigration, foreign authorities and the National Crime Agency.

**Online Safeguarding**

**Impact of the Online Environment for Information Communication Technology (ICT) on Children and Young People**

Communication technologies have become a significant tool in the distribution of indecent photographs/pseudo photographs of children. Internet chat rooms, social networking sites, gaming sites, virtual worlds, instant messaging, discussion forums and bulletin boards are used as a means of contacting children with a view to grooming them for inappropriate or abusive relationships, which may include requests to make and transmit indecent images of themselves, or to perform sexual acts live in front of a camera via live streaming services or other such platforms. Contacts made initially in a group environments such as a chat rooms or online forums are likely to be carried on and further developed through (typically encrypted) social media platforms as part of the grooming process.

There is also cause for concern about the exposure of children to inappropriate material such as adult pornography and/or extreme forms of obscene material, including access to extremist content and it is important to recognise that extremist radicalisation of young people is itself a form of grooming. Allowing or encouraging a child to view such material over an appreciable period of time may warrant further enquiry. Children themselves may engage in online bullying (Cyberbullying), deliberately send explicit images/video of themselves (Sexting) or use mobile phone cameras to capture violent assaults of other children for circulation;

Where there is evidence of a child using ICT technology (including gaming devices) excessively, this may be a cause for concern more generally, in the sense that it may inhibit the development of real-world social relationships, become a factor contributing to physical health and wellbeing, mental health concerns or negatively impact on their educational attainment. It may also indicate either a contemporary problem, or a deeper underlying issue that ought to be addressed, such as addictive behaviour and behaviour relating to the obsessive use of technologies, particularly around online gaming environments;

There is evidence that people found in possession of indecent photographs/pseudo photographs of children are likely to be involved directly in child abuse. Thus when somebody is discovered to have placed or accessed such material online, the Police should normally consider the likelihood that the individual is involved in the active abuse of children. In particular, the individual's access to children should be established, within the family, employment contexts, and in other settings (e.g. work with children as a volunteer or in other positions of trust);

If there are particular concerns about one or more specific children, procedures should be followed for Referrals, Single Assessments and, when appropriate, Strategy Discussions/Meetings. As part of their role in preventing abuse and neglect, Pan Lancs LSCBs are key partners in the development and delivery of training and education programmes, with the Child Exploitation and Online Protection Centre (CEOP). This includes building on the work of HM Government departments and organisations such as the UK Council for Child Internet Safety (UKCCIS), BECTA, the UK Safer Internet Centre (UKSIC) and IT-industry partners in raising awareness about the safe use of technology by our children and young people.

**Working Practices**

LSCB Organisations will:

Ensure that they have an appropriately trained person nominated as the lead Online Safeguarding Champion who receives regular updates on emerging trends / technologies and potential risks;

Promote that the use of Internet derived materials by service providers and children and young people complies with copyright law;

Provide guidance on using Social Networking platforms and other associated technologies safely and responsibly;

Provide guidance on managing inappropriate use of technology by children, young people and staff;

Encourage children and young people to be critically aware of online content including becoming critical consumers of information and promoting the development of broader digital resilience;

Encourage and support parents and carers to become more aware of online issue affecting children and young people and how to address them;

Ensure that they use digital images and video of children and young people responsibly and safely and encourage children, young people, their parents and carers to do the same;

Provide guidance on using online platforms positively, safely and responsibly;

Encourage the safe and responsible use of mobile technologies such as smartphones and tablets by children and young people;

Where agencies use social media, software and broader communication technologies to monitor if a child is suffering or likely to suffer significant harm, the agency must have in place robust and effective policies and procedures compliant with local information sharing protocols and safeguarding policies.

**Policy Decisions**

**Authorising Access to ICT**

All organisations must have robust and effective Acceptable Use/Behaviour Policies in place which users must read (and sign where applicable) before using any ICT resources;

The organisation should keep a record of all users (including staff and students) who are granted Internet access. The record will be kept up-to-date, for instance a member of staff may leave or a student's access be withdrawn;

Those with parental responsibility will be asked to sign and return a consent form.

**Assessing Risks**

The organisation will take all reasonable precautions to ensure that users access only appropriate material. Any inappropriate access, whether intentional or unintentional, will escalated in line with the organisation's E-Safety Policyand procedures;

The organisation will regularly audit Online Safety provision to establish if their policies and procedures are adequate, up to date and implemented effectively.

**Handling Online Safety-related Complaints**

Complaints of Internet misuse will be dealt with by the person supervising internet use in the first instance in line with established safeguarding procedures;

Any complaint about staff misuse must be referred to the management within the organisation in line with established safeguarding procedures;

Complaints of a child protection nature must be dealt with in a timely and effective manner in accordance with the organisation's child protection procedures;

Children and young people and those with parental responsibility will be informed of the complaints procedure on request.

**Communications Policy**

Introducing the E-Safety Policy to Children and Young People

Online Safety rules should be posted in all rooms with computer access and discussed with the Children and Young People at least annually;

Children, Young People and their Parents/Carers should be informed that network and Internet use can be monitored;

The importance of Online Safety will be explained by school staff to Children and Young People including the standards expected both inside and outside of the school environment, particularly in relation to the use of Social Media platforms.

**Staff and the E-Safety Policy**

All staff will be given the organisation's E-Safety Policy(or its equivalent) and its importance explained, including the requirement to maintain appropriate professional standards both inside and outside of the work environment (e.g. Social Networking Sites);

All staff must read and understand Part 1 of the DfE statutory guidance ‘Keeping Children Safe in Education’

Staff should be made aware that internet traffic may be monitored and traced to the individual device or login. Discretion and professional conduct is essential;

The organisation may use monitoring systems and/or software where this is available to ensure that inappropriate materials are not being stored or used on the organisation's equipment.

**Enlisting Parents' Support**

The attention of those with parental responsibility will be drawn to the organisation's Online Safety Policy.

**Parental responsibility**

All mothers and most fathers have legal rights and responsibilities as a parent - known as ‘parental responsibility’.

If you have parental responsibility, your most important roles are to:

* provide a home for the child
* protect and maintain the child

You’re also responsible for:

* disciplining the child
* choosing and providing for the child’s education
* agreeing to the child’s medical treatment
* naming the child and agreeing to any change of name
* looking after the child’s property

Parents have to ensure that their child is supported financially, whether they have parental responsibility or not.

**Parental responsibility for separated parents**

If you have parental responsibility for a child but you do not live with them, it does not mean you have a right to spend time with your children. However, the other parent must include you when making important decisions about their lives.

You do not always need to get the consent of the other parent for routine decisions, even if they also have parental responsibility.

If it’s a major decision (for example, one of you wants to move abroad with your children) both parents with responsibility must agree in writing.

You can [apply for a Specific Issue Order or Prohibited Steps Order](https://www.gov.uk/looking-after-children-divorce/apply-for-court-order) if you cannot agree. A judge will then make a decision which is in your children’s best interests.

You must make sure your children are financially supported, whether you have parental responsibility or not.

You can get help to [arrange contact with your children](https://www.gov.uk/looking-after-children-divorce/arranging-contact-with-your-children).

# **Who has parental responsibility?**

A mother automatically has [parental responsibility](https://www.gov.uk/parental-rights-responsibilities/what-is-parental-responsibility) for her child from birth.

A father usually has parental responsibility if he’s either:

* married to the child’s mother
* listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in)

You can [apply for parental responsibility](https://www.gov.uk/parental-rights-responsibilities/apply-for-parental-responsibility) if you do not automatically have it.

**Births registered in England and Wales**

If the parents of a child are married when the child is born, or if they’ve jointly adopted a child, both have parental responsibility.

They both keep parental responsibility if they later divorce.

### Unmarried parents

An unmarried father can get parental responsibility for his child in 1 of 3 ways:

* jointly registering the birth of the child with the mother (from 1 December 2003)
* getting a parental responsibility agreement with the mother
* getting a parental responsibility order from a court

**Births registered in Scotland**

A father has parental responsibility if he’s married to the mother when the child is conceived, or marries her at any point afterwards.

An unmarried father has parental responsibility if he’s named on the child’s birth certificate (from 4 May 2006).

## Births registered in Northern Ireland

A father has parental responsibility if he’s married to the mother at the time of the child’s birth.

If a father marries the mother after the child’s birth, he has parental responsibility if he lives in Northern Ireland at the time of the marriage.

An unmarried father has parental responsibility if he’s named, or becomes named, on the child’s birth certificate (from 15 April 2002).

## Births registered outside the UK

If a child is born overseas and comes to live in the UK, parental responsibility depends on the UK country they’re now living in.

## Same-sex parents

### Civil partners

Same-sex partners will both have parental responsibility if they were civil partners at the time of the treatment, eg donor insemination or fertility treatment.

### **Non-civil partners**

For same-sex partners who are not civil partners, the 2nd parent can get parental responsibility by either:

* [applying for parental responsibility](https://www.gov.uk/parental-rights-responsibilities/apply-for-parental-responsibility) if a parental agreement was made
* becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth

**Looked after Children**

If your child is taken into care because of a care order, your council will share responsibility for making [most of the important decisions](https://www.gov.uk/parental-rights-responsibilities/what-is-parental-responsibility) about your child’s upbringing, including:

* who looks after them
* where they live
* how they are educated

If you agree to your child becoming ‘looked after’ and there is no care order, you’ll continue to have parental responsibility for your child.

In either case, the council is responsible for:

* making sure that an appropriate standard of care is provided
* making sure only suitable people are employed to look after your child
* providing proper training and support to staff and foster carers
* listening to your child’s views and your views about care arrangements and taking their religion, race, culture and background into account
* making sure your child has someone independent to talk to and knows how to complain if necessary

The child may be placed with either:

* another relative
* a foster carer
* a children’s home

**Care orders**

A care order is given by a court. It allows a council to take a child into care. Under the [Children Act 1989](http://www.legislation.gov.uk/ukpga/1989/41/part/IV) a council can apply for a care order if it believes a child is suffering or at risk of suffering significant harm.

The court decides if the child can be taken into care.

Care orders last until:

* the child’s 18th birthday
* an order is made giving parental responsibility to another person - for example, through adoption or special guardianship
* the court lifts the order (this is called ‘discharging’ the order)

A child can only be taken into care if they are under 18.

**Making a complaint**

If your child is in care and you’re unhappy about their treatment, you can make a complaint. Talk to your child’s carer or social worker first and if you’re not happy, you can [complain to your council](https://www.gov.uk/complain-about-your-council).

**Support for parents**

The Family Rights Group Advice Service helpline provides confidential support for parents:

**Family Rights Group helpline**

Telephone: 0808 801 0366

Monday to Friday, 9:30am to 3pm

[Find out about call charges](https://www.gov.uk/call-charges)

# **Care proceedings**

The council can start ‘care proceedings’ if they’re very worried about a child.

They can apply for a ‘care order’ which means the council will have [parental responsibility for your child](https://www.gov.uk/parental-rights-responsibilities) and can determine where your child can live.

They can apply for a ‘placement order’ as well if they believe that the child should be adopted. This allows the council to place the child with suitable adopters.

## Interim care orders

At the start of care proceedings, the council asks the family court to make a temporary court order, called an ‘interim care order’.

If the court agrees, the council can take the child into care on a temporary basis. This can be for up to 8 weeks at first.

## Looking at the case

It can take up to 26 weeks for a court to decide what should happen to the child. Some complex cases can take longer.

During this time a social worker, an officer from the Children and Family Court Advisory and Support Service (Cafcass) and other people will be trying to understand the reasons why the child may be at risk. They will also look at what can be done to keep them safe.

They will talk to the parents and the child. They may talk to other family members or friends about looking after the child if they cannot safely live at home. The parents might also get support.

## Reports

The social worker and Cafcass officer will each write a report for the court. These will outline what they think should happen to the child.

They will include whether they think the child should be taken into care or stay with the family.

Once all the information has been gathered, there will be a court hearing.

**Peer Abuse**

Children, particularly those living away from home, are also vulnerable to physical, sexual and emotional bullying and abuse by their peers. Such abuse should always be taken as seriously as abuse perpetrated by an adult. It should be subject to the same safeguarding children procedures as apply in respect of any child who is suffering, or at risk of suffering, Significant Harm from an adverse source. A significant proportion of sex offences are committed by teenagers and, on occasion, such offences are committed by younger children. Staff and carers of children living away from home need clear guidance and training to identify the difference between consenting and abusive, and between appropriate and exploitative peer relationships. Staff should not dismiss some abusive sexual behaviour as 'normal' between young people, and should not develop high thresholds before taking action.

Work with children and young people who abuse others - including those who sexually abuse/offend - should recognise that such children are likely to have considerable needs themselves, and also that they may pose a significant risk of harm to other children. Evidence suggests that children who abuse others may have suffered considerable disruption in their lives, been exposed to violence within the family, may have witnessed or been subject to physical or sexual abuse, have problems in their educational development, and may have committed other offences. Such children and young people are likely to be Children in Need, and some will, in addition, be suffering, or at risk of suffering, Significant Harm, and may themselves be in need of protection. Children and young people who abuse others should be held responsible for their abusive behaviour, while being identified and responded to in a way that meets their needs as well as protecting others. Allegations of peer abuse will be taken as seriously as allegations of abuse perpetrated by an adult.

Three key principles should guide work with children and young people who abuse others:

There should be a coordinated approach on the part of Youth Justice, Children's Social Care, education (including educational psychology) and health (including Child and Adolescent Mental Health (CAMHS) agencies;

The needs of children and young people who abuse others should be considered separately from the needs of their victims. This should include both the risk posed to the child and the risk posed by the child;

An assessment should be carried out in each case of abuse, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour.

Where a professional has concerns that a child may cause harm to another child, it is important that information is shared between Agencies, to ensure that a risk management plan is in place. Information should be shared in accordance with Information Sharing and Confidentiality Procedures.

A social worker from the relevant locality team will carry out a Single Assessment. Different social workers will be allocated to the victim and to the child with the alleged abusive behaviour, even if they live in the same household, to ensure that both are supported through the process of the enquiry and that both their needs are fully assessed.

It should be recognised that disclosure of sexually inappropriate behaviour or abusive behaviour by a child can be extremely distressing for a parent/carer. The child and family should always be advised of their right to seek legal representation to support them through the process.

The Police should always consult with Targeted Services regarding cases that come to their attention in order to ensure that there is an assessment of the victim's needs and that in all cases there is an assessment of the alleged abusing child's needs. Each child should be referred to the locality team responsible for the area where the child resides.

Children with sexually abusive behaviour who are returning to the community following a custodial sentence or time in secure accommodation also require consideration through this procedure.

In all cases where the suspected or alleged abuser is a child, Targeted Services and the Police must convene a Strategy Meeting within the timescales set out. This will be chaired by a Quality Assurance Officer.

If the children involved are the responsibility of different local authorities, each must be represented at the Strategy Discussion which will usually be convened by the authority in which the victim resides.

Consideration should be given to separate Strategy Discussions being held for the child who is alleged to have abused another and for the alleged victim(s).

Care must be taken to ensure that the appropriate professionals attend the right meeting to ensure appropriate confidentiality. For example, school representatives should only attend for the student at their school. The Police officer and social worker who are investigating should attend both sets of Strategy Discussions. Where the abusing child is over 10 years a Youth Offending Team representative should be in attendance.

The Strategy Discussion must plan in detail the respective roles of those involved in the enquiries and ensure the following objectives are met:

Information relevant to the protection and needs of the alleged victim is gathered;

Any criminal aspects of the alleged abuse are investigated;

Any information relevant to any abusive experiences and protection needs of the child who is the alleged abuser is gathered;

Any information about the risks to self and others, including other children in the household, extended family, school, peer group or wider social network is gathered.

Section 47 Enquiry will be pursued in respect of the alleged abusing child when he/she is personally suffering or at risk of Significant Harm.

Where there is suspicion that the child who is the alleged abuser is also a victim of abuse the Strategy Meeting must decide the order in which the interviews should take place.

When a child is aged 10 or over and is alleged to have committed an offence the Police must undertake the first interview under the Police and Criminal Evidence Act 1984.

If a child is to be interviewed as a victim of or witness to an alleged offence under the provisions of the Achieving Best Evidence guidance and the child admits these offences, these incidents should normally be the subject of a separate interview.

In complex situations where there are a number of victims and possible abusers the Strategy Discussion should involve Group Managers to coordinate the process.

If it appears that the alleged abusing child is suffering or is at risk of Significant Harm the Section 47 enquiry and Single Assessment process will be followed.

In assessing a child or young person who abuses another, relevant considerations include:

The nature and extent of the abusive behaviours. In respect of sexual abuse, there are sometimes perceived to be difficulties in distinguishing between normal childhood sexual development and experimentation, and sexually inappropriate or aggressive behaviour. Expert professional judgment may be required, within the context of knowledge about normal child sexuality. It may be appropriate to undertake a joint assessment;

The context of the abusive behaviours;

The child's development and family and social circumstances (if a child is Looked After and is at risk of sexual offending due consideration must be given as to whether a Child Protection Conference /multi-agency plan is required);

Needs for services, specifically focusing on the child's harmful behaviour as well as the child's other significant needs;

The risks to self and others, including other children in the household, extended family, school, peer group or wider social network. This risk is likely to be present unless the opportunity for further abuse is ended, the young person has acknowledged the abusive behaviour and accepted responsibility, and there is agreement by the young abuser and his/her family to work with relevant agencies to address the problem.

Decisions for local agencies (including the Crown Prosecution Service where relevant) according to the responsibilities of each include:

The most appropriate course of action within the criminal justice system, if the child is above the age of criminal responsibility;

Whether the young abuser should be the subject of a Child Protection Conference;

What plan of action should be put in place to address the needs of the young abuser, detailing the involvement of all relevant agencies.

If there is a balance of probability that nothing abusive or inappropriate took place, then no further action may be required. However in cases of alleged sexual abuse, it is important to keep this separate from the issue of denial. Strength of denial by the child and/or the family should have no bearing on any decision about no further action.

If there is a continuing risk of Significant Harm, an Initial Child Protection Conference should be held. If the child becomes the subject of a Child Protection Plan, the coordination of services will continue through the Core Group, which should address the child's inappropriate behaviour as well as the concerns, which resulted in their need for a Child Protection Plan.

If the child is not considered as requiring a Child Protection Plan but is assessed to be a Child in Need, a meeting should be held, as set out in the paragraph below.

Where there are insufficient grounds for holding a Child Protection Conference, or where a Child Protection Plan was not needed, a multi-agency approach will still be needed if the young abuser's needs are complex.

In such cases a multi-agency planning meeting should be convened by Children's Social Care to pool information, allocate roles and set a time-table for an assessment of the needs of the child and the risk posed by them, as well as co-ordinate any other interim intervention.

Those invited should include participants of the Strategy Meeting and representatives from health (including Child and Adolescent Mental Health Services), school, YOT and any other appropriate service provider, the child and her/his parents / carers.

In cases where the young abuser is also looked after by the local authority consideration should be given to the need for a plan to minimise risk of future offending, agreed with carers and their agency.

On completion of the assessment, the same forum will be reconvened to consider the outcome, to review and co-ordinate roles of relevant agencies in providing any identified intervention, including specialist input with regard to service users with special needs. Care must be taken to provide services culturally appropriate to the needs of the child and the family.

Intervention should be reviewed at regular multi-agency meetings. At the point of closure, the review will consider the possible need for long-term monitoring and the availability of advice and other services.

Children's Targeted Services will undertake a multi-agency assessment when a young person has committed an offence against a child and is due to be released following a custodial sentence or time in secure accommodation.

**Criminal Proceedings**

When the child is over 10 years, the Police will consult other agencies including the Crown Prosecution Service to decide the most appropriate course of action within the criminal justice system before any decision is made to issue a reprimand, final warning or informal disposal, or to pursue prosecution.

In cases where criminal proceedings are taken against an alleged abusing child, the YOT should be added to the list of possible attendees at any meetings. Both the compilation of the YOT Asset Assessment and the preparation of a Single Assessment will be facilitated through this.

When a case is going through the Youth Court or the Crown Court, the YOT will provide information for the Single Assessment process. This may include plea, bail conditions and variations between adjournments.

LSCB's and Youth Offending Teams should ensure that there is a clear operational framework in place, within which assessment, decision-making and case-management take place. Neither child welfare nor criminal justice agencies should embark on a course of action that has implications for the other without appropriate consultation.

**The Child Victim**

Where the assessment of the child or children who have been abused concludes that they may still be at risk of Significant Harm, an Initial Child Protection Conference must be convened to assess the risks and safeguard them through a Child Protection Plan if needed.

They may require services to support them through interviews in line with Achieving Best Evidence Guidance. The assessments undertaken may determine that there is a need for support services, such as counselling services, whether the child is in need of safeguarding or a Child in Need.

**Bullying**

Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are:

Physical (e.g. hitting, kicking, theft);

Verbal (e.g. racist or homophobic remarks, threats, name-calling);

Emotional (e.g. isolating an individual from the activities and social acceptance of their peer group).

The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them Significant Harm (including self-harm). All settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

**Private Fostering**

**Introduction**

A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of the local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than:

A parent of the child;

A person who has parental responsibility for the child;

A close relative to the child.

with the intention that it should last for 28 days or more.

Private foster carers may be from the extended family, such as cousin or great aunt. However, a person who is a relative under the Children Act 1989 i.e. Grandparent, brother, sister, uncle or aunt (whether of the full or half blood or by marriage) or step-parent, will not be a private foster carer.

A private foster carer may be a friend of the family, the parent of a friend of the child, or someone previously unknown to the child's family who is willing to privately foster a child.

The period for which a child is cared for and accommodated by the foster carer is continuous, but that continuity is not broken by the occasional short break. If a period of care lasts less than 27 days but further periods are planned which total 28 days or more, then the private fostering procedures apply. A break in the period for the child to visit his/her parents at home for a brief period, e.g. weekend, would not effect the total calculation of the number of days of the placement. Such a break does not therefore constitute the end of the private fostering arrangement.

A child is not privately fostered while he/she is:

Being looked after by the local authority;

Placed in the care of a person who proposes to adopt him/her under arrangements made by an adoption agency in line with Adoption legislation;

A protected child;

In the care of any person in compliance with a supervision order made in criminal proceedings under the CYPA1969 or a supervision requirement under the Social Work (Scotland) Act 1995;

Liable to be detained, or subject to guardianship, under the Mental Health Act 1983(7).

A child is deemed to be privately fostered where a person assumes care in a personal capacity and not as part of their duties in relation to any one of the following establishments:

Any children's home;

Accommodation provided by or on behalf of any voluntary organisation;

Any school in which he/she is receiving full-time education;

Any health service hospital;

Any residential care home, nursing home or mental nursing home;

Any other home or institution provided, equipped and maintained by the Secretary of State.

A private fostering arrangement is made by parents or a person with parental responsibility, directly with the private carers not through a voluntary agency or social care department. The arrangement is not paid for nor arranged by the local authority. If the local authority is sufficiently involved in financing and planning such a placement then the arrangement falls within the responsibilities discharged to local authorities for "Looked After Children".

Private fostering is the arrangement made by the parent and the private foster carer. Local authorities do not approve or register private foster carers. A proper balance needs to be maintained between the rights of parents to make private arrangements for the care of their children, and other statutory duties towards privately fostered children.

Privately fostered children are a diverse and sometimes vulnerable group. They may include:

Children sent from abroad to stay with another family, usually to improve their educational opportunities;

Asylum-seeking and refugee children;

Children and young people who are staying with friends or other non-relatives;

Language students living with host families.

**Legal Basis**

Privately fostered children are not Looked After Children, and local authorities are not involved in the making of such arrangements. A Privately Fostered Child is not necessarily a 'child in need'.

Local authorities do not formally approve or register private foster carers. However, it is their duty to be satisfied that the welfare of children who are privately fostered within their area is satisfactorily safeguarded and promoted.

Under the Children Act 1989 private foster carers and those with Parental Responsibility are required to notify the local authority of their intention to privately foster or to have a child privately fostered, or where a child is privately fostered in an emergency. Teachers, health and other professionals should notify the local authority of a private fostering arrangement that comes to their attention, where they are not satisfied that the local authority has been or will be notified of the arrangement.

It is the duty of every local authority to be satisfied that the welfare of children who are privately fostered within their area is being satisfactorily safeguarded and promoted, and to ensure that such advice as appears to be required is given to private foster carers. In order to do so, they must visit privately fostered children at regular intervals. The minimum visiting requirements are set out in the regulations. They have the power to impose requirements on the private foster carer or, if there are serious concerns about an arrangement, to prohibit it.

The Children Act 1989 creates a number of offences in connection with private fostering, including for failure to notify an arrangement or to comply with any requirement or prohibition imposed by the authority. Certain people are disqualified from being private foster carers.

Local authorities are required to promote awareness in their area of requirements as to notification and to ensure that such advice as appears to be required is given to those concerned with children who are, or are proposed to be, privately fostered. This will include private foster carers (proposed and actual) and parents.

**Principles**

Privately fostered children will be protected from sexual, physical and emotional abuse and neglect and any concerns will be dealt with in line with procedures in this manual. Persons identified as unsuitable will be prevented from fostering a child privately.

Children's views wishes and feelings will be considered at all times. All assessments of prospective carers will focus on the carers' ability to meet the needs of children. Children's Social Care will work in partnership with parents and children, carers and their families, and other professionals and agencies to ensure that services are provided to meet assessed needs.

Private fostering service provision will be based on fair and equal access and anti-discriminatory practice. The arrangements for the care of privately fostered children will take a holistic and life long view of the child's needs to maximise their life chances. The child's parent and the private foster carers should work in partnership to promote the child's health and education.

All agencies should encourage parents and carers to notify Children's Social Care of any private fostering arrangements and take steps to check that notification takes place. Assessment of Private Fostering Arrangements will be undertaken using the Single Assessment and will be subject to Children's Social Care case management and supervision arrangements.

**Actions for Safeguarding**

All referrals to notify and request assessment for private fostering must be made through local Multi-Agency Safeguarding Hub (MASH) arrangements, including by social workers already working with a family. The MASH process will involve checks through Police (PNC, PND & Borders Agency) and determine allocation for assessment.

Children's Social Care will arrange for a social worker to visit the parents and talk about their child's needs and the proposed private fostering arrangements. The social worker will also visit the person who is fostering, or intends to foster the child within 7 days of receiving notification and will inspect the accommodation. Everyone over 16 years of age will be required to undergo checks including a Disclosure and Barring Service enhanced check.

If the Single Assessment identifies that the proposed arrangements would not be appropriate for the child, the child's parents will be offered appropriate advice and support to enable them to make alternative arrangements for the care of their child. Parents would also be advised on attachment issues and the desirability of keeping siblings together wherever possible, unless a child had particular needs that needed to be met separately.

The social worker will write a report about the arrangements, and a senior Children's Social Care manager will decide whether the placement should go ahead, and whether any restrictions should be made such as limiting the number of children that the carer can privately foster, or requiring that particular safety measures are taken in the home.

**Raising Awareness**

Section (7A) of Schedule 8 to the Children Act 1989, inserted by section 44 of the Children Act 2004, places a duty on local authorities to promote public awareness, in their area, of the notification requirements. Local authorities need to develop a programme of communication activities, including local authority staff, and arrange and distribute up to date publicity materials. They also need to make available information on the notification requirements which reflect the requirements of Schedule 1 to the Children (Private Arrangements for Fostering) Regulations 2005.

Local Authorities, when undertaking awareness-raising activities, should involve other agencies, such as schools and GPs' surgeries, so as to enable professionals in turn to encourage private foster carers and parents to notify the local authority. Other agencies need also to be aware that failure by a private foster carer or parent to notify a local authority of a private fostering arrangement is an offence, and if local authorities are not aware of such arrangements they cannot carry out their duty to satisfy themselves that the welfare of the children concerned is being satisfactorily safeguarded and promoted.

Education, health and other professionals should notify the local authority of a private fostering arrangement that comes to their attention, where they are not satisfied that the local authority have been, or will be, notified of the arrangement, so that the local authority can then discharge its duty to satisfy itself that the welfare of the privately fostered child concerned is satisfactorily safeguarded and promoted. This is, of course, a matter of good practice.

**Radicalisation**

Terrorism under the Terrorism Act 2000 is defined as action that endangers or causes serious violence to a person, causes serious damage to property, or seriously interferes or disrupts an electronic system. The use or threat of terrorism must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause;

Extremism is defined in the 2011 Prevent Strategy as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. The definition also includes calls for the death of members of British armed forces, whether in this country or overseas. Extremism can be by violent or non-violent means;

Radicalisation is defined as the process by which people come to support terrorism and 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;

Safeguarding in this context is the process of protecting vulnerable children and young people, whether from crime, other forms of abuse or being drawn into terrorism or extremism;

**National Guidance and Strategies**

In March 2015, the Government published the Prevent Duty Guidance on the duties within the Counter Terrorism & Security Act 2015. The Act places a duty on various specified authorities that all have an important role in Prevent delivery. The specified authorities include local authorities, education providers (across all ages), health sector, Police, and prison and probation services amongst others;

The new legislation builds upon the Prevent Strategy 2011, which aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorists, and has three specific strategic objectives:

Respond to the IDELOGICAL challenge and the threat faced by the UK from those who promote extremism and seek to radicalise people;

Prevent INDIVIDUALS from being radicalised and drawn into terrorism to ensure they are given the appropriate advice and support; and

Work with sectors and INSTITUTIONS where there are risks of radicalisation that need to be addressed.

These strategic objectives have become known as the three I’s. The Counter Terrorism & Security Act 2015 requires that all specified agencies (including through their commissioned services and services they have licensing or health and safety responsibilities for) will work in partnership to deter, disrupt and prosecute. In the context of safeguarding, to use the powers under the Children Act 1989 and Children Act 2004 to safeguard and protect children who may be being radicalised, involved in extremism or terrorism.

Channel: Protecting vulnerable people from being drawn into terrorism: A guide for local partnerships was published by HM Government in October 2012 and updated in 2015. The Channel programme is an initiative led by the Police and partners, which operates to provide support to people at risk of being drawn into extremism;

The Channel Guidance identifies a multi-agency approach to protect vulnerable people by:

Identifying individuals at risk;

Assessing the nature and extent of that risk; and

Developing the most appropriate support plan for the individuals concerned.

**Understanding and Recognising Risks and Vulnerabilities of Terrorism or Extremism**

Children and young people can be drawn into terrorism or they can be exposed to the messages of extremist groups by many means. Children and young people are vulnerable to exposure to, or involvement with, groups or individuals who advocate terrorism as a means to a political or ideological end. Examples of extremist causes where individuals or groups have used violence or non-violent means to achieve their ends include animal rights, the far right, environmentalists, domestic, single issue activists and international terrorist organisations;

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 (see Online Safeguarding Procedure and How Social Media is Used to Encourage Travel to Syria and Iraq (DfE / Home Office)) This can put a child or young person at risk of being drawn into criminal activity and has the potential to cause Significant Harm;

Most individuals, even those who hold radical views, do not become involved in extremism. Numerous factors can contribute to and influence the range of behaviours that are defined as extremism. It is important to consider these factors in order to develop an understanding of the issue. It is also necessary to understand those factors that build resilience and protect individuals from engaging in extremist activity;

It is important to be cautious in assessing these factors to avoid inappropriately labelling or stigmatising individuals because they possess a characteristic or fit a specific profile;

It is vital that all professionals who have contact with vulnerable individuals are able to recognise those vulnerabilities and help to increase safe choices;

It is necessary to remember that extremist behaviour operates on many levels in the absence of protective factors and that individuals largely act within the context of their environment and experiences;

Research shows that indicators of vulnerability can include:

Identity Crisis - Distance from cultural / religious heritage and uncomfortable with their place in the society around them;

Personal Crisis - Family tensions; sense of isolation; adolescence; low self-esteem; disassociating from existing friendship group and becoming involved with a new and different group of friends; searching for answers to questions about identity, faith and belonging;

Personal Circumstances - Migration; local community tensions; events affecting country or region of origin; alienation from British values; having a sense of grievance that is triggered by personal experience of racism or discrimination or aspects of Government policy;

Unmet Aspirations - Perceptions of injustice; feeling of failure; rejection of civic life;

Criminality - Experiences of imprisonment; poor resettlement / reintegration; previous involvement with criminal groups.

However, this list is not exhaustive, nor does it mean that all young people experiencing the above are at risk of exploitation for the purposes of extremism – individuals may show some, all or none of the vulnerabilities;

The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame. Given this, it is important that awareness, sensitivity and expertise are developed within all contexts to recognise signs and indications of radicalisation;

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. This can put a young person at risk of being drawn into criminal activity and has the potential to cause Significant Harm;

Potential indicators identified by the Channel Guidance include:

Use of inappropriate language;

Possession or accessing violent extremist literature;

Behavioural changes;

The expression of extremist views;

Advocating violent actions and means;

Association with known extremists;

Articulating support for violent extremist causes or leaders;

Using extremist views to explain personal disadvantage;

Joining or seeking to join extremist organisations;

Seeking to recruit others to an extremist ideology.

Annex C of the Channel Duty Guidance 2015 provides the Vulnerability Assessment Framework that Channel Panels will use to guide decision making. It is also a useful tool for agencies to use to guide their assessment and referral decision making processes;

No research has identified a definitive list of indicators which would show that someone is vulnerable to radicalisation to violent extremism. Rather, 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;

Some children may be at risk due to living with or being in direct contact with known extremists or individuals suspected to be involved in the radicalisation process. Such children may be identified by the Police or through MAPPA processes (See Processes for Managing Risk Procedure) or by all agencies through the allegations against people who work with children processes (LADO);

Should it come to a worker’s attention that an individual has been arrested for terrorism, extremism or radicalisation offences, the worker should consider with their agency’s safeguarding lead whether safeguarding measures need to be taken in respect of the family members and connected / influenced individuals of the arrested individual. The Chair of the Channel Panel and Police Channel Co-ordinators will be able to advise on these matters and on wider safeguarding measures (emergency protection or Police protection orders) to reduce vulnerability.

**Channel: Referral and Intervention Processes**

Like child protection, Channel is a multi-agency safeguarding programme run in every local authority in England and Wales. It works to support vulnerable people from being drawn into terrorism and provides a range of support such as mentoring, counselling, assistance with employment etc. Channel is about early intervention to protect vulnerable people from being drawn into committing terrorist-related activity and addresses all types of extremism.

Participation in Channel is voluntary. It is up to an individual, or their parents for children aged 17 and under, to decide whether to take up the support it offers. Channel does not lead to a criminal record.

Staff working with children should use the model below to assist them in identifying and responding to concerns about children who may be vulnerable to radicalisation or being drawn into extremist activity;

Early identification of concerns should result in responses being made through Universal provision (Tier 1) or through targeted interventions (Tier 2). Diagram 1 below, Appropriate, proportionate responses and interventions gives examples of appropriate and proportionate responses at each tier. The headings for the examples follow the four aspects of the Learning together to be safe Toolkit and further guidance and activities can be found in the Learning Together to be Safe Workbook;

In a few cases, an individual may move beyond being vulnerable to extremism to involvement or potential involvement in supporting or following extremist behaviour. Where this is identified as a potential risk, further investigation by the Police will be required, prior to other assessments and interventions;

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 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;

The Channel Referral process outlined below (diagram 2) should be used to guide the named or designated safeguarding professional in making the referral;

Some children who are at risk of being drawn into extremist activity may pose a risk to others. There must not be a conflict between the welfare needs of the child/young person perpetrator and the victim; agencies have a duty to safeguard both. Many perpetrators/abusers are in need of care and protection themselves; however, they must also be held accountable for their own actions;

The named or designated safeguarding professional should consider whether a situation may be so serious that an emergency response is required. Staff should exercise professional judgement and common sense to identify whether an emergency situation applies; examples in relation to violent extremism are expected to be very rare but would apply when there is information that a violent act / life threatening act is imminent or where weapons or other materials may be in the possession of a young person, another member of their family or within the community or imminent to travel to a conflict zone. In this situation, a 999 call should be made.

The Pan-Lancashire Channel Panel Chair is Paul Lee, Head of Operations and Safeguarding (Blackburn with Darwen Borough Council). Meetings are held on a monthly basis. If you have any concerns about someone and would like more advice ring 101/999 if urgent, if not then email concern@lancashire.pnn.Police.uk. Any information, advice or concern will be handled with sensitivity and where possible anonymity will be maintained. Referrals can be made directly to the email inbox by any individual or organisation and will be dealt with discretion.

Reporting online material, which promotes extremism such as illegal or harmful pictures or videos, can be done through the government website (Report online material promoting terrorism or extremism (GOV.UK)). Although professionals should follow the Making a Referral to Children's Social Care Procedure, non professionals may make a report anonymously.

Some concerns which are identified may have a security dimension to them. For this reason, it is important that liaison with the Police forms an early part of all investigations.

The named or designated safeguarding professional, in discussion with other professionals (including the local Police Prevent team) as appropriate, will need to determine the most appropriate level and type of support to offer the child and their family:

Tier 1 - Universal Responses and Support - Wherever possible the response should be appropriately and proportionately provided from within the normal range of universal provision of the organisation working with other local agencies and partners. Responses could include curriculum provision, additional tutoring or mentoring, additional activities within and out of school, family support;

Tier 2 - Targeted Responses and Support - Where a higher level of targeted and multi-agency response is indicated a formal multi-agency assessment should be conducted. The Early Help Assessment (EHA) may be used with parents/carers’ agreement. Support may come from several agencies and be co-ordinated via Team Around the Child (TAC) meetings. A formal plan, based on the level of need either a Early Help Assessment or Child in Need Plan should be completed and a lead person nominated (for CIN Plans the lead will be a social worker);

Tier 3 - Specialist Support - Where a child is thought to be at risk of significant harm, and/or where investigations need to be carried out (even though parental consent is withheld) a referral to Social Care should be made. However, it should be recognised that concerns of this nature in relation to extremism are most likely to require a Police investigation (as part of Pursue) in the first instance. The multi-agency assessment will involve the Police in the making of decisions about the appropriate response. All cases at this level will be reported to Social Care who would monitor all referrals and make regular reports to the Local Safeguarding Children Board and the local Area Partnership Board for Prevent.

For all types of response, where services and agencies are referring directly to specialist services commissioned through ‘Prevent’ initiatives, rather than through the Channel Panel, it is important to notify the local Prevent Co-ordinator of this referral;

For all types of response, a clear plan must be developed and documented to set out how the needs of the child will be met, and who will have responsibility for doing this. Early discussion with either the Prevent Coordinator or officers in the local Prevent team will allow the designated safeguarding professional to decide if a referral to the Channel Panel is required, or if services at tier 1 or 2 are sufficient to manage any risks. The plan will include agreed arrangements for review of progress;

A discussion with the local Prevent team will advise how the referral can be made;

The Channel Panel will discuss each new referral to determine where multi-agency response, co-ordination and review are beneficial. Also at each meeting, all Channel Panel cases will be reviewed to determine if services are effective in safeguarding the child or young person and reducing the risks of radicalisation and extremism. All services, provided at any tier, will have a responsibility to the Channel Panel to regularly report on progress being made. The local Prevent team on behalf of the Channel Panel chair will co-ordinate responses and attendance to the Channel Panel;

Reviews must be carried out at the agreed intervals, or sooner if a change in circumstances indicates this is appropriate. All reviews should be documented appropriately and records retained by services and agencies working with the child or young person. Where a child is being provided services through Early Help Assessment, CIN, CPP or LAC processes, the review by the Channel Panel will report into the relevant multi-agency processes;

Unless it is deemed appropriate to end the agreed response, each review meeting should agree dates of further reviews, along with the person responsible for convening the review meeting and the people who should be involved in this;

All those involved with the child or young person should continue to monitor the situation, and consider modifying the response if circumstances change. If the risk is perceived to diminish, it may be appropriate to end the response. However, if the risk is perceived to increase, an escalation of the response may be required and may take the case outside of the ‘Prevent’ strand of the CONTEST strategy;

Where the Channel Panel response ends it may be that the child or young person still has outstanding needs being met through Early Help Assessment, CIN, CPP or YOT processes. These processes should continue to be reviewed until all needs are met. Every case from the Channel Panel that has ended will be reviewed 6-12 months after exiting the process to ensure there are no new risks or intelligence that require a response. Where new risks or intelligence suggest a repeat of concerns the assessment process can be restarted at any point. Agencies where they become aware of new or repeat risks should not wait for the 6-12 month review, and must discuss the concerns immediately with their local Prevent team. The outcome of Channel Panel reviews will be shared with lead professionals in Early Help Assessment, CIN, CPP & LAC processes.

**Local and National Support**

If you are concerned about the safety or welfare of a child please contact:

Blackburn with Darwen Children’s Social Care

Lancashire Children’s Social Care

Blackpool Children's Social Care Social Work Team

For Strategic or Policy Support or advice contact Blackburn with Darwen or Burnley Prevent Co-ordinators:

Medina Patel

Prevent Co-ordinator

Community Safety Team

Blackburn with Darwen Borough Council

Environment, Housing & Neighbourhoods

3rd Floor, Old Town Hall

Blackburn

BB1 7DY

Tel: 01254 585 263

Email: [Medina.Patel@blackburn.gov.uk](mailto:Medina.Patel@blackburn.gov.uk)

Rob Grigorjevs

Programme & Projects Co-ordinator

Burnley Borough Council

Burnley Town Hall

Manchester Road

Burnley

Lancashire

BB11 9SA

Tel: 01282 477112

Mobile: 07854 784 611

For non urgent safeguarding concerns around terrorism, extremism and radicalisation, email the Police Channel Team on concern@lancashire.pnn.Police.uk.

Duty Desk: 01772 412 742 (8am to 6pm weekdays).

Out of Hours: Contact Police on 101 or 999 – ask that the Duty Inspector and Force Incident Manager are made aware and make necessary contact with Counter-Terrorism Branch.

For advice and arrangements for training: Prevent Teams can be contacted on:

East Lancashire (BwD, Burnley, Pendle etc) – 01254 353 541;

West/South/North Lancashire (Blackpool, Lancaster, Chorley etc) – 01772 209 733;

National Prevent Training can be accessed at the E-Learning Training on Prevent website (Home Office);

National E-learning on the Channel Panel can be accessed at the Channel General Awareness website.

**Religious Beliefs and Linked Abuse**

**Key Considerations**

The following points can assist in understanding the issues and actions to safeguard children from, abuse or neglect linked to a belief in spirit possession are:

Child abuse is never acceptable in any community, in any culture, in any religion, under any circumstances. This includes abuse that might arise through a belief in spirit possession or other spiritual or religious beliefs;

Everyone working with or in contact with children has a responsibility to recognise and know how to act on evidence, concerns, and signs that a child's health, development and safety is or may be being impaired, especially when they suffer or are at risk of Significant Harm;

Standard child safeguarding procedures apply and must always be followed in all cases where abuse or neglect is suspected including those that may be related to a belief in spirit possession. Children suffering or at risk of suffering from such abuse or neglect will be identified and appropriately safeguarded if statutory procedures are implemented correctly. Anyone with concerns that a child may have suffered, or is likely to suffer Significant Harm should follow the procedures in Part 3 of this manual for Managing Individual Cases where there are concerns about a child's safety and welfare;

Child abuse linked to a belief in spirit possession sometimes stems from a child being used as a scapegoat. Whilst specific beliefs, practices, terms or forms of abuse may exist, the underlying reasons for the abuse are often similar to other contexts in which children become at risk of poor outcomes due to factors such as family stress, deprivation, domestic violence, substance abuse and or mental health problems. In addition, children who are different in some way, perhaps because they have a disability, an illness, learning needs, or are exceptionally bright, might be targeted in this kind of abuse. In some cases, there will be no obvious difference and the child will have been targeted because they will have been perceived to be 'spiritually' different;

The number of identified cases of such abuse is small but where it does occur the impact on the child is great, causing much distress and the child will be suffering Significant Harm. It is possible that a significantly larger number of cases remain undetected;

Professionals with safeguarding responsibilities need to be able to identify links, where they exist, between individual cases of such child abuse and individual faith leaders as well as wider belief, faith or community practices. Where connections are identified and appropriate action is taken, the risk that other children will be similarly abused can be greatly reduced. In some cases, links to a belief in possession may not come to light until some way into the investigation of abuse. Where the concerns relate to a number of children, consideration should be given to whether the Complex (Organised and Multiple) Abuse Procedure should be implemented;

Local agencies and institutions should also work to minimise risk of harm, by building trust and understanding of child abuse issues with local communities. Robust local partnerships advance early identification and safeguarding of children. Local agencies and institutions share responsibility for safeguarding and promoting the welfare of children and young people. They should act if they have concerns about a child's welfare, and ensure that practices that lead to abuse that may be linked to a belief in spirit possession or any other belief, are challenged and stopped;

People working with children should always take advice whenever they feel it is required, in accordance with information sharing protocols and guidance. The fact that a suspected case of abuse or neglect may be linked to spirit possession can initially seem daunting. It is important to use the experience of colleagues, including those in other services, to overcome misgivings and understand complexities. A child's safety and welfare must always come first.

**Definitions and Incidence**

The term 'belief in spirit possession' is defined for the purposes of this guidance as the belief that an evil force has entered a child and is controlling him or her. Sometimes the term 'witch' is used and is defined here as the belief that a child is able to use an evil force to harm others. There is also a range of other language that is connected to such abuse. This includes black magic, kindoki, ndoki, the evil eye, djinns, voodoo, obeah, demons, and child sorcerers. In all these cases, genuine beliefs can be held by families, carers, religious leaders, congregations, and the children themselves that evil forces are at work.

Families and children can be deeply worried by the evil that they believe is threatening them, and abuse often occurs when an attempt is made to 'exorcise', or 'deliver' the child. Exorcism is defined here as attempting to expel evil spirits from a child.

The number of identified child abuse cases linked to a belief in spirit possession is small especially when compared to the total number of children known to be abused. Research by Stobart (2006) reviewed child abuse cases that had occurred since January 2000. Thirty-eight cases involving 47 children were found to be relevant and sufficiently documented. This is in comparison to 26,400 children on Child Protection Registers in England at 31st March 2006. Indicators reported in the cases usually involve children aged between 2 and 14, both boys and girls, and have generally been reported through schools or non-governmental organisations. Whilst the number of identified cases is small, the nature of the child abuse can be particularly disturbing and the impact on the child is substantial and serious. The abuse may be carried out by the child's parents or carers or others in the family network, as well as by faith leaders.

**Forms of Abuse**

The abuse usually occurs in the household where the child lives. It may also occur in a place of worship where alleged 'diagnosis' and 'exorcism' may take place.

The most common forms of abuse include:

Physical Abuse: in the form of beating, shaking, burning, cutting, stabbing, semi-strangulating, tying up the child, or rubbing chilli peppers or other substances on the child's genitals or eyes, or placing chilli peppers or other substances in the child's mouth;

Emotional/psychological abuse: in the form of isolation, for example, not allowing a child to eat or share a room with family members or threatening to abandon them, or telling a child they are evil or possessed. The child may also accept the abuse if they are coerced into believing they are possessed;

Neglect: in the form of failure to ensure appropriate medical care, supervision, regular school attendance, good hygiene, nourishment, clothing or keep the child warm;

Sexual abuse: children abused in this way may be particularly vulnerable to sexual exploitation, perhaps because they feel powerless and worthless and feel they will not be believed if they tell someone about the abuse.

There have been reported cases of individuals who present themselves as faith leaders/healers being paid by parents and carers to 'exorcise' children. The belief that a child is possessed can be supported by faith leaders and the child, and in some cases the family may be ostracised by community members. The child can come to hold the belief that they are possessed and this may be harmful in itself and can significantly complicate their rehabilitation.

Where such abuse or neglect is identified, some children are placed in an alternative family, through long-term foster care or adoption, and some are returned to the family home within the framework of a child protection plan.

Where abuse exists but is not identified, or there is no intervention to safeguard the child's welfare, children may continue to be severely abused. There are also circumstances where carers or parents believe that a child has passed evil spirits to an unborn child, and professionals will need to be mindful that a pre-birth assessment may be required, and that children subsequently born into the household may be vulnerable to harm.

**Why are Children Abused or Neglected in this Way?**

It is not helpful to stereotype those who might abuse or neglect a child because of a belief in spirit possession. A belief in 'spirits' and 'possession' is relatively widespread, whilst abuse linked to such beliefs is rare. This kind of abuse is not confined to particular countries, cultures, religions or communities. Abusers may appear to be quite ordinary and may be family members, family friends, carers, faith leaders or other figures in the community. There are, however, a number of common factors that put a child at risk of harm:

Rationalising misfortune by attributing it to spiritual forces: As in many child abuse cases, abuse linked to a belief in spirit possession generally occurs when problems within a family or in their broader circumstances exist. In these particular cases a spiritual explanation is sought in order to rationalise misfortune. Child abuse can occur when rationalisation takes the form of believing oneself to be cursed and that a child is the source of the problem because they have become possessed by evil spirits;

A child is scapegoated because of an obvious or perceived difference: The reason why a particular child is singled out and accused of being possessed is complex. It often results from a combination of a weak bond of affection between a child and parent or carer, a belief that the child is violating family norms and above all a perception that the child is 'different '. It may be that the child is being cared for by adults who are not the parents, and who do not have the same affection for the child as their own children. A child can also be viewed as being different for disobedience, rebelliousness, over independence, bedwetting, nightmares, illness, perceived or actual physical abnormality or a disability. Disabilities involved in documented cases included learning disabilities, mental health, epilepsy, autism, a stammer and deafness. Many of the children were also described by their families or carers as being naughty. In other cases there were no obvious reasons, but a perceived issue;

Belief in evil spirits: In the cases identified by Stobart's (2006) research (see Child Abuse Linked to Accusations of Possession and Witchcraft), every child had an accusation of 'evil' made against him or her. This was commonly accompanied by a belief that they could 'infect' others with such 'evil'. The explanation for how a child becomes possessed varies widely but includes through food that they have been given or through spirits that have been in contact with them;

Social factors: A range of social factors that may make a child more vulnerable to accusations of being possessed were also identified by Stobart (2006). These included:

Changes in family structure or dynamics - The research found that children had become more vulnerable following a change in family structure. Carers often had new, transient or several partners. The family structure also tended to be complex so that exact relationships to the child were not immediately apparent. This may mean the child is living with extended family or in a private fostering arrangement. In some cases this may even take on a form of servitude;

A family's disillusionment with life or negative experience of migration - In the majority of identified cases the families were first or second generation migrants to the UK. The research suggested that the families often suffered from the difficulties and stress of migration including isolation from extended family, a sense of not belonging, alienation or feeling threatened or misunderstood, as well as significantly unfulfilled expectations of quality of life;

A parent's or carer's mental health - In over a quarter of identified cases there were concerns for the mental health of a parent or carer. The illnesses involved included post-traumatic stress disorder, depression and schizophrenia.

In working to identify such child abuse or neglect it is important to remember every child is different.

Some children may display a combination of indicators of abuse whilst others will attempt to conceal them. In addition to the social factors above, there is a range of common features across identified cases. These indicators of abuse, which may also be common features in (other kinds of abuse), include:

A child's body showing signs or marks, such as bruises or burns, from physical abuse;

A child becoming noticeably confused, withdrawn, disorientated or isolated and appearing alone amongst other children;

Deterioration of a child's personal care - 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;

Lack of concern or close bond between the child and his or her parent or carer;

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'.

**Assessment**

Professionals who have concerns about a child's welfare should discuss these concerns with their manager or a designated member of staff, or a Named Professional.

Whilst there is a need to be culturally sensitive in working with families where there are these concerns, it is important to remain mindful that the safety and protection of the child are paramount. In view of the nature of the risks a full medical assessment of the child should be considered to establish the overall health of the child, the medical history and the current circumstances.

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 dealing with - it can often take a number of visits to recognise such abuse.

In cases of suspected abuse linked to a belief in spirit possession it may be particularly useful to consider the following:

**How do I understand the particular risk of harm to the child?**

The completion of a Common Assessment Framework assessment may provide a helpful way of gathering and summarising information about a child so as to clarify whether there is a safeguarding concern or whether other action to assist the child should be undertaken.

**How do I build a relationship of trust with the child?**

Children and young people will usually stick to their account and not speak until they feel comfortable. It will be important to spend time with the child alone and build a relationship of trust. It is important to ascertain the child's wishes and feelings and understand the environment in which the child lives;

The child must be seen and spoken to on his/her own. Their bedroom or sleeping arrangements must be inspected.

**What are the beliefs of the family?**

Beliefs in spirits and possession are widespread. The key feature in cases of abuse is not the beliefs of a family, but that the perpetrator of abuse uses these beliefs as a justification for abuse of a child;

You should seek advice if you are dealing with a culture or set of beliefs that you do not understand, or which are unfamiliar to you. Professionals need to have an understanding of religious beliefs and cultural practices in order to help gain the trust of the family or community. The use of correct terminology will help to build up trust with the child and family. Asking questions or seeking advice about a culture, religion, or set of beliefs you are not familiar with.

**What is the family structure?**

In cases of abuse linked to a belief in possession, the relationship between the child and their carer may be unclear. These cases of abuse will sometimes relate to the arrival of a new adult into the household, or the arrival of the child, perhaps from abroad. What are the roles of the adults in the household? Who looks after the child? Is the child being privately fostered? If the child has recently arrived, what was their care structure in their country of origin? What is the immigration status of the child? The identities and relationships of all members of the household should be identified, including with documentation. It may be appropriate to consider DNA testing.

**Are there reasons why the child might be picked on?**

Are they different from other children in the family or community? Are they disabled? Have their parents been labelled as possessed? Do I need a professional interpreter? What is the preferred language of the child and family? There may be a need for neutral, high quality, gender-appropriate translation or interpretation services. Children should never be expected to interpret on behalf of adults or other family members. If working with a very small community, what is the relationship between interpreter and the family? Are they part of the same social network?

**Action to Safeguard**

In order to safeguard and promote the welfare of the child in these cases it may be particularly useful to consider:

**What pressures are the family under?**

Is there anything you can do to address relevant pressures on the family? These cases of abuse will sometimes relate to blaming the child for something that has gone wrong in the family;

Involve the family: A belief that the child is possessed may mean they are stigmatised in their family. Do members of the family have the same views about the situation? If the child has been labelled as possessed, how does this affect their relationship with others in the extended family and community?

Is the perpetrator of abuse isolated?

The perpetrator may believe that they are doing what they should to rid the child of evil spirits and might even believe that they are not harming the child.

Are these beliefs supported by others in the family or in the community?

Would it help to involve a senior faith leader?

Any evidence that the parent or carers will take the child out of the country/abandon the child must be taken seriously.

Anyone with concerns that a child may have suffered, or is likely to suffer Significant Harm linked to spiritual or religious beliefs should follow the procedures in Part 3 of this manual for Managing Individual Cases where there are Concerns about a Child's Safety and Welfare.

**Services to Support Children**

Abuse of a child linked to a belief in possession can take the form of physical, emotional or sexual abuse and neglect. In some cases the abuse can be very severe and there may be a substantial psychological impact on the child, particularly if they are ostracised by the family or community or if they themselves believe that they are possessed.

The services that a child needs will depend on their individual circumstances but services that may be particularly relevant to such abuse include:

Children's Social Care, including a placement away from home in foster care, residential care, or adoption;

Child and Adolescent Mental Health Services (CAMHS): it may also be appropriate to engage adult mental health services to assess and where appropriate work with the perpetrator of abuse and/or child's parents or carers;

Health services, especially for victims of severe abuse or neglect;

Faith groups, the family's faith community may need advice from Children's Social Care. They may be able to help a family understand how to treat their child and offer support to the child or family to help promote the welfare of the child. However, care should be taken to establish whether the faith group that the victim's parents or carers are affiliated to support the practice of abusive exorcism. Social workers may also want to seek advice from faith groups to aid their understanding of reasons behind any abuse;

Wider family support services from the statutory and voluntary sector;

A multi-agency response: There will be a variety of different agencies in the community involved with children and their development. Professionals should be aware of the services that are available locally to support the child and how to gain access to them;

The Police: Where a social worker believes that a criminal offence may have been committed, they or their manager should discuss the child with the Police at the earliest opportunity;

Schools: Schools may identify concerns about children. Where a child of school age is the subject of a child protection plan the school should be involved in the preparation of the plan, and where appropriate in its delivery.

**Concerns about a Place of Worship**

Concerns about a place of worship may emerge where:

A lack of priority is given to the protection of children and there is a 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 children or that a display of repentance for an act of abuse is seen to mean that an adult no longer poses a risk of harm;

There is a denial or minimisation of the rights of the child or the demonization of individuals;

There is a promotion of mistrust of secular authorities;

There are specific unacceptable practices that amount to abuse.

Services should consider how best to tackle the concerns, whether intervention is needed to safeguard children and whether concerns can be addressed through influence and engagement.

**Safeguarding Children and Young People in the Youth Justice System**

**Legal Requirements**

The Children Act 1989 applies to children and young people in the secure estate and the local authority continues to have responsibilities towards them in the same way as they do for other Children in Need. LSCB's will have oversight of the safeguarding arrangements within secure settings in their area;

The Youth Justice Board (YJB) has a statutory responsibility for the commissioning and purchasing of all secure accommodation for children and young people who are sentenced or remanded by the courts. It does not deliver services directly to young people but is responsible for setting standards for the delivery of those services;

There are three types of secure accommodation in which a young person can be placed, which together make up the secure estate for children and young people:

Young Offender Institutions (YOI's) - YOI's are facilities run by both the Prison Service and the private sector and accommodate 15- to 17-year-olds. Young people serving Detention and Training Orders can be accommodated beyond the age of 17 subject to child protection considerations. The majority of YOI's accommodate male young people, although there are four dedicated female units;

Secure Training Centres (STC's) - STC's are purpose-built centres for young offenders up to the age of 17. STC's can accommodate both male and female young people who are held separately. They are run by private operators under contracts, which set out detailed operational requirements. There are four STC's in England;

Secure Children’s Homes (SCH's) - Most SCH's are run by local authority children’social care. They can also be run by private or voluntary organisations. They accommodate children and young people who are placed there on a secure welfare order for the protection of themselves or others, and for those placed under criminal justice legislation. SCH's are generally used to accommodate young offenders aged 12 to 14, girls up to the age of 16, and 15 to 16-year-old boys who are assessed as vulnerable.

All these establishments have a duty to effectively safeguard and promote the welfare of children and young people, which should include:

Protection of harm from self;

Protection of harm from adults; and

Protection of harm from peers.

Local authorities, LSCB's, YOT's and secure establishments should have agreed protocols setting out how they will work together and share information to safeguard and promote the welfare of children and young people in secure establishments.

All members of staff working in secure establishments have a duty to promote the welfare of children and young people and ensure that they are safeguarded effectively.

In addition, Governors, Directors and senior managers have a duty to ensure that appropriate procedures are in place to enable them to fulfil their safeguarding responsibilities. These procedures should include, but not be limited to, arrangements to respond to:

Child protection allegations;

Incidents of self-harm and suicide; and

Incidents of violence and bullying.

All staff working within secure establishments should understand their individual safeguarding responsibilities and should receive appropriate training to enable them to fulfil these duties. Appropriate recruitment and selection processes should be in place to ensure staff’s suitability to work with children and young people. These procedures should cover any adult working within the establishment, whether or not they are directly employed by the Governor/Director.

**Actions to Safeguard**

If a child in custody in an establishment in the region makes allegations about abuse that happened before they entered the custodial establishment, or it becomes clear that they may be at risk of Significant Harm on leaving the establishment, a referral should be made to Making a Referral to Children's Social Care Procedure.

Children’s Social Care will:

Co-ordinate an Assessment;

Convene, if required a Strategy Discussion to consider whether to initiate a Section 47 Enquiry; and

Liaise with any other Local Authority in whose area the child was living or will be living, or where the abuse is alleged to have taken place, where appropriate.

The Manager of the Record of Children subject to a Child Protection Plan should be notified of any serious incidents or if a child dies in custody in an establishment in the region. If the child was ordinarily resident in the region, the Serious Case Review Panel will then consider whether to commission a Serious Case Review - see the Serious Case Reviews Procedure.

**Children of Prisoners**

Where there is concern for the welfare of a prisoner’s child within a custodial establishment, the procedures in Part 3, Managing Individual Cases where there are concerns for the welfare and safety of a child, will apply.

**Self-Harm or Suicidal Ideation**

**Introduction**

This is Pan Lancashire multi-agency guidance for those working with children who Self-harm or have the potential for Suicide and their families.

This guidance seeks to support staff in working with children to reduce the potential damage self-harm can cause to both the child's physical body and to their mental well-being, e.g. self-esteem and provide them with the information required to make confident, informed and consistent decisions and responses when dealing with a child who has self-harmed.

This care pathway document recognises that young people who self-harm are doing so as a coping mechanism, and that just telling them to stop does not work.

This guidance advocates a 'harm reduction/minimisation' approach. Both the child and member of staff will be working towards replacing the self-harming behaviours with less risk taking and potentially life threatening coping strategies.

Children who self-harm mainly do so because they have no other way of coping with problems and emotional distress in their lives. This can be to do with factors ranging from bullying to family breakdown. But self-harm is not a good way of dealing with such problems. It provides only temporary relief and does not deal with the underlying issues.

**Who is this Document for?**

It is for all those working in the Children and Young People workforce, primarily for use with:

Children identified as using self-harm as a coping strategy;

Children when they require access to specialist mental health services as a result of self-harm, suicide ideation and/or attempted suicide.

**Definitions to Support the Care Pathway**

Child

This is any child under the age of 18.

Suicide

Suicide is an intentional, self-inflicted, life-threatening act resulting in death from a number of means.

Suicidal intent

This is indicated by evidence of premeditation (such as saving up tablets), taking care to avoid discovery, failing to alert potential helpers, carrying out final acts (such as writing a note) and choosing a violent or aggressive means of deliberate self-harm allowing little chance of survival.

Self-harm

Lancashire's Youth and Community Service conducted some research with young people in 2002 and produced a paper which offers a helpful baseline (Coupe et al, 2002):

"Self-harm might be described as the term used to describe the coping strategy that some people use to deal with stresses in their life:

It involves a person hurting themselves physically;

Self-harm often takes the form of a person cutting, burning or banging themselves;

According to the young people who participated, self-harm is often about "surviving", "coping", "taking control", "release of pressure", "distraction from other stuff - places/people", "complex emotions".

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered.

Self-harm can involve:

Cutting, often to the arms using razor blades, or broken glass;

Burning using cigarettes or caustic agents;

Punching and Bruising;

Inserting or swallowing objects;

Head banging;

Hair pulling;

Restrictive or binge eating;

Overdosing;

Problematic substance misuse;

Frequent and repetitive risk taking behaviour e.g. taking away and driving cars, 'playing chicken'.

(Mental Health Foundation 2006)

The term self-harm is often used as an all encompassing term referring to suicidal ideation and attempted suicide.

Some young people who self-harm may say that they want to die and a proportion of them may genuinely want to. Nevertheless, self-harm and suicide differ in terms of the intent behind the behaviour - self-harm is motivated by the desire to endure and survive. Understandably, many people assume that when a person injures themselves they are making a suicide attempt. But "self injury is not the same thing as a suicide attempt, in fact it is usually something very different: a desperate attempt to cope and to stay alive in the face of great emotional pain" (Arnold and Magill, 1996).

Despite these differences, self-harm is associated with an increased risk of suicide, since both actions are based in distress. For example, someone may resort to suicide when self-harm no longer works for them as a coping strategy. Some motivations for self-harming 'overlap' with suicidal motivations: when, for example, a person feels ambiguous about whether the action kills them or not, and given the risks inherent in self-harm, a small proportion of people who self-harm may kill themselves accidentally. As a result, statistics indicate that people who self-harm are more likely to commit suicide (e.g. Hawton 1992) - although the often hidden nature of self-harm means that statistics can be unrepresentative.

**Why do some Young People Self-Harm?**

Research indicates that a number of factors may motivate young people to self-harm and the list below is not exhaustive:

To express emotional distress: "you're showing other people how much you're hurting inside"; (Bywaters and Rolfe 2002)

Release and relief from pressure: "it's like a release. It feels better after I've taken tablets"; (Spandler 1996)

Letting bad feelings 'out': "getting all the anger and the hurt out, and the pain"; (Bywaters and Rolfe 2002)

Distraction from emotional pain: "Taking the pain away from what's in your head and transferring it onto your body"; (Bywaters and Rolfe 2002)

To gain control over seemingly out-of-control situations and feelings: "You've got to have control over something"; (Spandler 1996)

To induce a pleasurable state: "my whole body goes kind of calm"; (Bywaters and Rolfe 2002)

To feel special, to express individuality: "I took a certain pride in being able to take pain. It was like

I was good at something"; (Spandler 1996)

To physically express emotional pain: "it's my way of turning emotion and pain, and things like that into something physical, which is a lot easier to handle in the long-run". (Bywaters and Rolfe 2002)

According to "Youth and self-harm" (Samaritans 2002), the most common reasons given for self-harm by school-age young people were 'to find relief from a terrible state of mind'. Contrary to popular belief, few were 'trying to frighten someone' or 'get attention'.

**Risk Factors**

**Issues that may trigger self-harm**

A number of factors may trigger the self-harm incident:

Family relationship difficulties (the most common trigger for younger adolescents);

Difficulties with peer relationships e.g. break up of relationship (the most common trigger for older adolescents);

Bullying;

Significant trauma, e.g. bereavement, abuse;

Self-harm behaviour in other students (contagion effect);

Self-harm portrayed or reported in the media;

Difficult times of the year (e.g. anniversaries);

Trouble in school or with the Police;

Feeling under pressure from families, school and peers to conform/achieve;

Exam pressure;

Times of change (e.g. parental separation/divorce).

Individual factors:

Previous deliberate self-harm or suicide attempt;

Intent - does the young person wish to die? What do they understand by death? Do they think that what they have done, or are planning to do, will kill them? N.B. it is the young person's perception of or belief in potential lethality that is important here, not what a professional thinks;

Evidence of mental illness, especially depression, anxiety, psychosis or eating disorder;

Poor problem-solving skills - are problems seen as over-whelming? Does the young person see themselves as capable of solving, or coping with, problems? Have they been able to solve problems in the past? May be linked to poor communication skills;

Impulsivity/planning - Were steps taken to avoid discovery? Were any preparations for death made? A tendency to impulsive behaviour may increase risk of repetition and thus the likelihood of significant harm, but evidence of planning may indicate higher levels of seriousness for any given attempt. But remember that an impulsive act can be just as damaging as a planned one;

Substance use including alcohol and volatile substances (especially important in impulsive males);

Hopelessness - is there a future, or any reason to continue living? What plans for the future does the young person have? This has been described as "the missing link" between depression and suicide. It can be especially significant if there has been previous deliberate self-harm or attempts at suicide;

Anger/hostility/anti-social behaviour - some research suggests conduct disorder may be a higher risk factor than depression. This may be difficult to assess, as information will be needed from sources other than the young person;

Low self esteem;

Drug or alcohol abuse.

**Family factors:**

Instability (this can mean more than divorce or separation and can include repeated house moves). History of depression, deliberate self-harm, suicide or mental illness in the family, especially in first-degree relatives. History of substance use. Arguments or disputes can be important;

History of neglect or abuse, whether physical, emotional or sexual, but especially the latter;

Has the young person experienced prolonged parenting style characterised by "High Criticism and Low Warmth"?

Experiencing or witnessing domestic abuse;

Loss or bereavement - this may include such things as loss of status as well as deaths. Anniversaries of losses can be significant;

Unreasonable expectations;

Poor parental relationships and arguments.

**Social factors**:

Persistent bullying, peer rejection or other victimisation, such as experiencing racial or sexual discrimination, and including homophobic bullying (see next point);

Issues of gender or sexual orientation - a very high proportion of young people who either are homosexual or think they might be, self-harm or attempt suicide;

Current stressors or life events;

Absence of a supportive helping network (could be family, extended family, peers, or professional);

Absence of a trusted approachable adult;

Difficulty in making relationships/loneliness;

Easy availability of drugs, medication or other methods of self-harm.

**Other considerations:**

Function of deliberate self-harm (other than a clear suicide attempt) - what did the young person hope the act would achieve: a sense of relief or release; punishment; purification; a desire to feel physical rather than emotional pain; a form of communication of distress or other significant matter; something else?

Method of self-harm - be aware of unintended consequences, such as liver damage from repeated 'Paracetamol' overdoses, stomach ulceration from aspirin overdose, brain damage from oxygen starvation in attempted hanging, drowning or exhaust poisoning, or bone damage resulting from jumping;

Time of year may be significant, especially when school-related factors are involved, such as bullying or exams. Hence the start of terms or exam periods may see an increase in self-harming behaviour;

Young people may be highly ambivalent in their views of themselves and any act of self-harm.

**Responding to Self-Harm**

Immediate response to injuries

It is ok and appropriate to show concern. Make sure the child / young person is safe; give them something to treat any injuries (e.g. plaster or bandage) and/or seek medical advice and attention as required. Encourage the young person to seek medical attention if they are reluctant and provide the necessary support to facilitate this.

The young person who has just harmed themselves usually feels upset and vulnerable (although they may hide this). Just because they caused the harm to themselves this does not mean that they will not feel hurt, frightened or shocked by their injuries. Be reassuring rather than questioning them at this stage. They may want to talk, so allow for this.

People often fear that being sympathetic will somehow 'reinforce' the behaviour as an 'attention-seeking' strategy, thereby perpetuating it and possibly making it worse. In fact, being punitive, hostile or withholding care and support is likely to make the young person feel even worse about themselves, thereby increasing risk. (However, avoid 'amateur' psychology and/or therapy at all costs, unless you are trained and/or qualified to provide either or both!)

**Messages to give young people**

It is usual for people to feel shocked, frightened, anxious and/or upset when they first encounter a child or young person who is self-harming. However, the messages that adults give at this initial point of contact are crucial:

Calmness - Remain calm and do not openly display the very powerful feelings of shock, anger, distress or panic that you may have;

Acceptance - Tell the young person that it is okay to talk about self-harm, it is something that you know about and can handle;

Acknowledgement - Tell the young person how hard it can be to talk about this and acknowledge the courage that it takes to do so;

Concern - Demonstrate that you are concerned about the distress which lies behind the self-harm;

Understanding - Make it clear that self-harm is something that can be understood, that there are reasons for it and that other young people do it too - they are not alone;

Respect and Reassurance - Acknowledge their use of this particular coping strategy and with how frightening it might feel if they think someone is going to take it away;

Hope - Some people who self-harm think it absolutely impossible to stop; let them know that lots of people who do it are able to stop hurting themselves;

Information - Provide information about appropriate resources and sources of further help, advice and support but do not rush the young person on to someone else; remember that being available to listen and talk is important in itself and avoids giving messages of being fobbed off or that the problem is simply too big for anyone to deal with);

Confidentiality - Respect confidentiality whilst ensuring that appropriate procedures are followed. The 'usual' balance needs to be struck here e.g. make it clear why and to whom you may have to pass information on and encourage and support a young person to talk to an appropriate person.

**Levels of Risk and Suggested Action**

**Related Risk**

**Action**

Suicidal thoughts are fleeting and soon dismissed

Ease distress as far as possible. Consider what may be done to resolve difficulties

No plan

Link to other sources of support

Few or no signs of depression

Make use of line management or supervision to discuss particular cases and concerns

No signs of psychosis

Review and reassess at agreed intervals

No self-harming behaviour

Consider completing a Early Help Assessment

Current situation felt to be painful but bearable

**Raised Risk**

**Action**

Suicidal thoughts are frequent but still fleeting

Ease distress as far as possible. Consider what may be done to resolve difficulties

No specific plan or immediate intent

Consider safety of young person, including possible discussion with parents/carers or other significant figures

Evidence of current mental disorder, especially depression or psychosis

Seek specialist advice

Significant drug or alcohol use

Possible mental health assessment - discussion with, for example, service's safeguarding champion, primary mental health workers in CAMHS/AMHS

Situation felt to be painful, but no immediate crisis

Consider consent issues for the above

Previous, especially recent, suicide attempt

Consider increasing levels of support/professional input

Current self-harm

Review and reassess at agreed intervals - likely to be quicker than if risk is low

**High Risk**

**Action**

Frequent suicidal thoughts, which are not easily dismissed

Ease distress as far as possible. Consider what may be done to resolve difficulties

Specific plans with access to potentially lethal means

Safety - discussion with parents/carers or other significant figures more likely

Evidence of current mental illness

Request for Specialist CAMHS involvement

Significant drug or alcohol use

Consider consent issues

Situation felt to be causing unbearable pain or distress

Consider increasing levels of support/professional input in the mean time

Increasing self-harm, either frequency, potential lethality or both

Monitor in light of level of Specialist CAMHS involvement

N.B. at any time during assessment and review, emergency medical treatment may be found to be necessary or child protection concerns may be raised. See Making a Referral to Children's Social Care Procedure.

Direct referral route to Specialist or Emergency Care

Based on the notion that the level of perceived risk could change at any time, ongoing support systems need to be put in place irrespective of the level of risk.

Ongoing support may take many forms and may be offered via numerous sources and will be dependent on the child or young person's needs and wishes.

**Do's and Dont's**

**Do's**

Make an assessment of risk e.g. emergency medical attention;

Take suicide gestures seriously;

Be yourself, listen, be non-judgemental, patient, think about what you say;

Check associated problems such as bullying, bereavement, relationship difficulties, abuse, and sexuality questions;

Check how and when parents will be contacted;

Encourage social connection to friends, family, trusted adults;

Implement initial care pathway;

Implement support/contact with young person;

Seek risk assessment from those in your service who have been trained to provide this level of assessment;

Make appropriate referrals;

Using Early Help Assessment processes set up a meeting to plan the care pathway interventions based upon an understanding of the risks and difficulties;

Provide opportunities for support, and to strengthen existing support systems.

**Don'ts**

Jump to quick solutions;

Dismiss what the children or young people are saying;

Believe that a young person who has threatened to harm themselves in the past will not carry it out in the future;

Disempower the child or young person;

Ignore or dismiss people who self-harm;

See it as attention seeking;

Assume it is used to manipulate the system or individuals;

Trust appearances.

**Sexually Active Young People Under the Age of 18**

**Introduction**

Each LSCB has developed a protocol with the understanding that most young people under the age of 18 will have an interest in sex and sexual relationships. Where sexual activity involving children and young people below the age of legal consent comes to the attention of agencies, it will not necessarily be appropriate to initiate the child protection procedures;

The protocols are designed to assist those working with children and young people to identify where these relationships may be abusive, and the children and young people may need the provision of protection or additional services. They are based on the core principle that the welfare of the child or young person is paramount, and emphasise the need for professionals to work together in accurately assessing the risk of Significant Harm when a child or young person is engaged in sexual activity;

This policy is about the protection of vulnerable children engaging in risk taking behaviour not the criminalisation of young people. The decision to prosecute offenders under the age of 16 will be taken on a case by case basis and only after consultation with other child protection agencies. Prosecution will not be the default position.

**Allegations of Harm Arising from Underage Sexual Activity**

The child's best interests must be the overriding consideration in making any such decision including in the cases of underage sexual activity on which detailed guidance is given below. The Information Sharing and Confidentiality Procedure provides advice on these issues. Any decision whether or not to share information must be properly documented. Decisions in this area need to be made by, or with the advice of, people with suitable competence in child protection work such as Named Professionals or senior managers;

A child under 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate a risk of Significant Harm to the child;

Cases involving under-13s should always be discussed with a Named Professional in the organisation. Under the Sexual Offences Act, penetrative sex with a child under 13 is classed as rape. Where the allegation concerns penetrative sex, or other intimate sexual activity occurs, there would always be reasonable cause to suspect that a child, whether girl or boy, is suffering or is likely to suffer Significant Harm. All cases of sexually active under 13 year olds must be reported to Children's Social Care and a Strategy Discussion held.

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

Cases of concern should be discussed with the nominated Named Professional and subsequently with other agencies if required. Where confidentiality needs to be preserved, a discussion can still take place as long as it does not identify the child (directly or indirectly). Where there is reasonable cause to suspect that Significant Harm to a child has occurred or might occur, the case should be reported to Children's Social Care (see Making a Referral to Children's Social Care Procedure) and a Strategy Discussion should be held to discuss appropriate next steps. Again, all cases should be carefully documented including where a decision is taken not to share information.

**Assessment**

All young people, regardless of gender, or sexual orientation who are believed to be engaged in, or planning to be engaged in, sexual activity must have their needs for health education, support and/or protection assessed by the agency involved;

In assessing the nature of any particular behaviour, it is essential to look at the facts of the actual relationship between those involved. Power imbalances are very important and can occur through differences in size, age and development and where gender, sexuality, race and levels of sexual knowledge are used to exert such power. Of these, age may be a key indicator, e.g. a 15 year old girl and a 25 year old man. There may also be an imbalance of power if the young person's sexual partner is in a position of trust in relation to them e.g. teacher, youth worker, carer etc. In the assessment, workers need to include the use of sex for favours e.g. exchanging sex for clothes, CDs, trainers, alcohol, drugs, cigarettes etc. Young people could also have large amounts of money or other valuables which cannot be accounted for;

If the young person has a learning disability, mental disorder or other communication difficulty, they may not be able to communicate easily to someone that they are, or have been abused, or subjected to abusive behaviour. Staff need to be aware that the Sexual Offences Act 2003 recognises the rights of people with a mental disorder to a full life, including a sexual life. However, there is a duty to protect them from abuse and exploitation. See Legal Framework for Child Protection Procedure for more information. The Act includes 3 new categories of offences to provide additional protection;

In order to determine whether the relationship presents a risk to the young person, the following factors should be considered. This list is not exhaustive and other factors may be needed to be taken into account:

Whether the young person is competent to understand and consent to the sexual activity they are involved in;

The nature of the relationship between those involved, particularly if there are age or power imbalances as outlined above;

Whether overt aggression, coercion or bribery was involved including misuse of substances/alcohol as a disinhibitor;

Whether the young person's own behaviour, for example through misuse of substances, including alcohol, places them in a position where they are unable to make an informed choice about the activity;

Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship;

Whether the sexual partner is known by the agency as having other concerning relationships with similar young people;

If accompanied by an adult, does that relationship give any cause for concern?

Whether the young person denies, minimises or accepts concerns;

Whether methods used to secure compliance and/or secrecy by the sexual partner are consistent with behaviours considered to be 'grooming';

Whether sex has been used to gain favours (e.g. swap sex for cigarettes, clothes, CDs, trainers, alcohol, drugs etc);

The young person has a lot of money or other valuable things which cannot be accounted for.

It is considered good practice for workers to follow the Fraser Guidelines when discussing personal or sexual matters with a young person under 16. The Fraser Guidelines give guidance on providing advice and treatment to young people under 16 years of age. These hold that sexual health services can be offered without parental consent providing that:

The young person understands the advice that is being given;

The young person cannot be persuaded to inform or seek support from their parents, and will not allow the worker to inform the parents that contraceptive/protection, e.g. condom advice, is being given;

The young person is likely to begin or continue to have sexual intercourse without contraception or protection by a barrier method;

The young person's physical or mental health is likely to suffer unless they receive contraceptive advice or treatment;

It is in the young person's best interest to receive contraceptive/safe sex advice and treatment without parental consent.

**Process**

In working with young people, it must always be made clear to them that absolute confidentiality cannot be guaranteed, and that there will be some circumstances where the needs of the young person can only be safeguarded by sharing information with others. This discussion with the young person may prove useful as a means of emphasising the gravity of some situations. See Information Sharing and Confidentiality Procedure;

On each occasion that a young person is seen by an agency, consideration should be given as to whether their circumstances have changed or further information has been given which may lead to the need for Referral or re-referral. In some cases urgent action may need to be taken to safeguard the welfare of a young person. However, in most circumstances there will need to be a process of Information Sharing and discussion in order to formulate an appropriate plan. There should be time for reasoned consideration to define the best way forward. Anyone concerned about the sexual activity of a young person should initially discuss this with the Named Professional in their agency. There may then be a need for further consultation with Children's Social Care. All discussions should be recorded, giving reasons for action taken and who was spoken to. It is important that all decision making is undertaken with full professional consultation, never by one person alone (agency procedures must include guidance on how this is to be undertaken within their own organisation);

If you have concerns that the young person may be at risk of sexual exploitation through prostitution, please refer to Children's Social Care by completion of a Multi-Agency Assessment and Referral Form for Blackpool or the Early Help Assessment form for Blackburn with Darwen and Lancashire. If the situation is an emergency, the local Police should be contacted immediately. When a Referral is received by Children's Social Care, a check will be made as to whether the child/ young person is the subject of a Child Protection Plan, followed by a Strategy Discussion with partner agencies include the Police. This discussion should be informed by the Assessment undertaken using this protocol and, in the majority of cases, may be largely for the purposes of consultation and information sharing;

In many cases, it will not be in the best interests of the young person for criminal or civil proceedings to be instigated. However, Police and Children's Social Care and other agencies may hold vital information that will assist in any clear assessment of risk;

Following any Referral to Children's Social Care and after a Strategy Discussion with the Police and/or any other agencies there may be one of these responses:

No further action deemed necessary;

An Single Assessment undertaken which may identify the young person as a Child in Need and additional services provided;

An Single Assessment undertaken which may identify the young person as a child at risk of Significant Harm and in need of child protection intervention;

The outcome of the Referral will be formally fed back to the referring agency;

A referral will be made through Health and/or the Police to the SAFE centre for forensic and medical examinations and emotional support.

During this process agencies must continue to offer the service and support to the young person.

Any girl, either under or over the age of 13, who is pregnant, must be offered specialist support and guidance by the relevant services. These services will also be a part of the assessment of the girl's circumstances, and must be included within local guidance. An Early Help Assessment should always be considered for any teenager who is known to be pregnant Young People Under the Age of 13.

**Young People Under the Age of 13**

Under the Sexual Offences Act 2003, children under the age of 13 are considered of insufficient age to give consent to sexual activity. The Police must be notified as soon as possible when a criminal offence has been committed or is suspected of having been committed against a child unless there are exceptional reasons not to do so;

In all cases where the sexually active young person is under the age of 13, a Referral to Children's Social Care must be made. In order for this to be meaningful, the young person will need to be identified, as will their sexual partner if details are known;

When a girl under 13 is found to be pregnant, a Referral to the Children's Social Care must be made and they will hold a Strategy Discussion with the Police and/or other agencies. At this stage a multi agency support package should be formulated.

**Young People Between 13 and 16**

The Sexual Offences Act 2003 reinforces that, whilst mutually agreed, non-exploitative sexual activity between teenagers does take place and that often no harm comes from it, the age of consent should still remain at 16. This acknowledges that this group of young people is still vulnerable, even when they do not view themselves as such;

Sexually active young people in this age group will still have to have their needs assessed using this protocol. Discussion with Children's Social Care will depend on the level of risk/need assessed by those working with the young person;

This difference in procedure reflects the position that, whilst sexual activity under 16 remains illegal, young people under the age of 13 are not capable to give consent to such sexual activity.

**Young People Between 16 - 18**

Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures under the Children Act 1989. Consideration still needs to be given to issues of sexual exploitation through prostitution and abuse of power in circumstances outlined above. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. Young people over the age of 16 and under the age of 18 are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by the Sexual Offences Act 2003.

**Sharing Information With Parents and Carers**

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

**Transfer Across Local Authority Boundaries**

**Introduction**

Local agencies and professionals, working with children and families who move where there are outstanding child welfare concerns should consult their organisations procedures and refer to the appropriate agencies in the area the child and family have moved to, in the same way that referrals would be made for children and families who had remained living within their originating authority;

Any professional who receives a referral from another agency that a child whose case is open to Children's Social Care in another local authority has moved to stay in the region on a permanent or temporary basis should bring this information to the attention of the relevant Children's Social Care team. They will consult departmental records to ascertain whether the child was previously known to them, and will telephone the relevant Children's Social Care office to discuss the case in order to determine what action if any is necessary. A letter requesting a case transfer summary will be sent to the referring local authority within 2 days. The case will not be accepted until this summary is received. On receipt of the requested information a letter of receipt will be returned within 2 days and a decision will be taken about what further action is needed.

**Responsibility for Children Who Require Immediate Protection**

In any locality where a child is found to be in need of protection, that local authority will take responsibility for ensuring the child is provided with such protection. For example, if a child originating from another local authority is found to be in need of immediate protection whilst they are in a different area then the local Children's Social Care where the incident takes place will ensure that such protection is provided;

The authority in which the incident takes place should notify the Children's Social Care in the child's originating authority of the action they have taken and involve them in planning any further action to be taken and future case management responsibility, Only if the originating authority are prepared to accept responsibility are the resident authority absolved from responsibility to take action.

**Children who are Subject of a Child Protection Plan who Move Out of the LSCB Area**

Whoever receives information about a child with a Child Protection Plan moving out of the LSCB area should immediately notify the social worker for the family;

The social worker is responsible for immediately notifying the relevant Manager and other relevant professionals and for contacting the new area to notify them of the move, request a transfer in conference and agree any visiting arrangements on behalf of the relevant Children's Social Care office. The relevant Children's Social Care Manager will send a letter to their counterpart for the area where the family has moved/is moving to, to formally alert them to the situation. The social worker should make direct contact with the professionals involved and their equivalent colleagues in the new area, and should ensure all relevant information is transferred;

The child/children will continue to have the Child Protection Plan monitored and reviewed by the relevant professionals. Children's Social Care will retain case management responsibility pending a transfer Child Protection Conference taking place in the receiving area, when the relevant professionals in the inter agency network will be informed of and consider the child and family's changed circumstances, and decide the further action necessary, including the continuation of the Child Protection Plan.

**Children Subject to a Child Protection Plan Moving into the LSCB Area**

Any worker who receives information about a child who is the subject of a Child Protection Plan in another authority moving into the LSCB area should immediately alert the relevant Children's Social Care Safeguarding Manager. A referral will be made and a record made that the child is subject of a Child Protection Plan in another area pending an initial Transfer-in Child Protection Conference. The Safeguarding Unit will ensure that key agencies likely to become involved with the child are notified that the child has moved into the area and is the subject of a Child Protection Plan in another authority;

The originating authority will maintain case responsibility, pending the case being transferred at the first Child Protection Conference held in the relevant area;

All transfer in conferences should be held within 15 working days from notification to the Safeguarding Manager that the child and family's move to the region is a permanent one. It will be necessary for the relevant departments to obtain reports from their equivalent colleagues in the originating area.

**Uncooperative Families**

**Introduction**

There is a wide array of behaviours exhibited by families towards workers which may be considered uncooperative. This may range from those who are apparently (but not genuinely) compliant, reluctant, or resistant, to those who are angry or aggressive in their response to practitioner involvement. In extreme cases there can be intimidation, abuse, threats of violence and actual violence.

Whilst most practitioners have experienced such responses at some time, the concept of uncooperative families is particularly relevant to the case of Baby Peter and Victoria Climbie. The tragic consequences for such children, is extremely well known and, in relation to the first two children has been comprehensively investigated and reported (Laming, 2003; Laming 2009). The Serious Case Review held following the death of Child D noted:

It is particularly difficult for staff in universal health services, who are not child protection specialists, to safeguard children where parents are not only culpably neglectful, but are also deliberately untruthful, evasive and manipulative of visiting practitioners. This review shows that the style and level of intervention that was provided to this family was not strong enough to break through the façade created by the parents. The result was that no agencies became aware of the unsuitable living conditions and inadequate care of the children. (Child D Serious Case Review, 2008).

Such cases should always be borne in mind when working with uncooperative families.

However, if a worker feels intimidated, they must consider what it must be like for a child or young person living in the household. The welfare of the child / young person is paramount at all times.

The aim of this document, therefore, is to provide staff in all services and whatever their role, with useful guidance when working with uncooperative families. A worker’s purpose in making contact with a family varies depending on their role and their agency; workers need to use this procedure accordingly. They need to be clearly aware of the level of authority they represent and therefore how far they are required to engage with the family.

This guidance should be used in conjunction with the NSPCC research, Ten pitfalls and how to avoid them- What research tells us.

**The procedure aims to:**

Assist workers in understanding the variety of ways in which non-cooperation can be displayed by families;

Help workers in understanding the causes of such responses;

Increase awareness of strategies workers may be able to employ in order to reduce the likelihood of non-co-operation;

Help workers maintain control of situations and keep themselves safe;

Help workers to be in a position to effectively assess the risk factors affecting children in the household, and ensure children are safeguarded and their welfare promoted.

This guidance aims to help you make an authoritative response to the resistant family, making it clear that non co-operation is not acceptable.

In such situations you and your colleagues should reach a view about whether a family is displaying ambivalence but with whom you can work, or deliberate behaviour which means change is much more difficult to achieve, therefore a more authoritative approach is needed. In such cases a decision may have to be made about whether the child/ren should be allowed to remain with the parents / carers.

All agencies need to be mindful of the need for workers to be trained for the level of work they are undertaking.

It is helpful if agencies publish a clear statement about unacceptable behaviour by those accessing their services (such as seen in hospitals and on public transport)

This procedure should be considered alongside individual practitioner codes of conduct. It is not intended to replace in-house self-defence / safety training in place within organisations.

**Recognising and Making Sense of Lack of Co-operation**

A common pattern of non-cooperation is when parents / carers do not comply with what has been agreed with them. As a result practitioners become stricter in their approach, and start imposing more rules, for example. The parent / carer may, as a result, make an appointment to appease the practitioner, with the GP, dentist, health visitor etc., but then does not attend. They have a plausible excuse for their non-attendance and make another appointment, which they subsequently do not attend. Each time the uncooperative parent / carer does just enough to keep practitioners away.

There are other types of uncooperativeness, as outlined below. This is not an exhaustive list.

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. No service user is without ambivalence at some stage in the helping process. We are all ambivalent about the dependency involved in being helped by others. It may reflect cultural differences, not being clear about what is expected, or be about poor previous experiences of involvement with practitioners. Ambivalence may need to be acknowledged, but it can be readily worked through;

Avoidance is a very common method of uncooperativeness and includes avoiding appointments, missing meetings, and cutting short visits due to other apparent important activity (often because the prospect of involvement makes the person anxious and they hope to escape it). Extreme avoidance may include not answering the door, as opposed to not being in. They may clearly have a problem, have something to hide, resent outside interference or find staff changes difficult. They may face up to the contact as they realise the worker is resolute in their intention, and may become more able to engage as they perceive the worker’s concern for them and their wish to help;

Confrontation includes challenging practitioners, provoking arguments, and often indicates a deep-seated lack of trust leading to a ‘fight’ rather than ‘flight’ response to difficult situations. Parents / carers may fear, perhaps realistically, that their children may be taken away or they may be reacting to them having being taken away. They may have difficulty in consistently seeing the worker’s good intent and be suspicious of their motives. It is important for the worker 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 /carer’s uncooperativeness must be challenged, so that they become aware that the worker / agency will not give up. If the worker involved faces this kind of confrontation and verbal aggression, they should seek advice and support from their manager in finding the most effective way to continue to work with the family (see Section 10, Keeping Workers Safe);

Violence: 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 worker / agency will need to be realistic about the capacity for change in the context of an offer of help with the areas that need to be addressed. If necessary the children should be referred for Section 47 enquiries, and this may entail them being removed from the family home for assessment. Keeping workers safe in such situations is vital (see Section 10, Keeping Workers Safe).

**Reasons for Non-co-operation Families**

There are a variety of reasons why some families may be uncooperative with practitioners, including:

They do not want their privacy invaded;

They have something to hide;

They don’t think they have a problem;

They resent outside interference;

They perceive there are cultural differences;

They do not understand what is being expected of them;

They have previously had poor experience of involvement with practitioners;

They resent staff changes;

They dislike or fear authority figures;

They fear their children will be taken away;

They fear being judged to be poor parents because of substance misuse, domestic abuse, mental health or other problems;

They feel they have nothing to lose, for example when the children have already been removed.

It is important to remember that a range of social, cultural and psychological factors influence the behaviour of parents / carers, as well as issues such as substance use or mental health. See also Drug Misusing Parents/Carers Procedure and Mental Illness of a Parent or Carer Procedure. But the more uncooperative the family, the more likely it is that the main influences are psychological, stemming from the parent / carer’s adverse experiences in their own childhoods. Some people, for whatever reason, may also have aggressive and violent traits in their personality. As an adult, the parent / carer will try to regain control over their lives, but they may be overwhelmed by pain, depression, anxiety and guilt resulting from their earlier loss. Paradoxically the uncooperativeness may occur as they open up their feelings, albeit negative ones, at the prospect of help. They may not be aware of this process going on.

**Isolation of a Child or Young Person**

Uncooperative parents / carers may isolate their children from agency involvement, especially if they are attempting to hid abuse or neglect that is taking place within the family. Indicators of a child being isolated in such a way may include significant periods of absence from school, or non-engagement with health agencies such as GP, health visitor, specialist health practitioner etc.

A child or young person’s absence from school may be supported by the parent or carer.

Therefore they may not be recorded as removed from school or truanting. This may mean they do not come to the attention of the Children Missing from Education Team as they are officially still attending significant periods of absence should be monitored by schools and early years settings (although attendance at early years setting is not a statutory requirement), and action taken according as specified within the school’s procedures, for example referral to the Educational Welfare Officer.

**Impact on the Assessment of Children, Young People and Families**

Accurate information and a clear understanding of what is happening to a child / young person within their family and community, is vital to any assessment. The usual and most effective way to achieve this is by engaging parents and their 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 / carer who is resistant or even violent and / or intimidating is obviously more difficult. The behaviour may be deliberately used to keep practitioners at bay, or can have the effect of keeping practitioners at bay. There may be practical restrictions to the ordinary tools of assessment - for example, observing the child in their own home. The usual sources of information, for example other workers and other family members may also be kept at bay by the family.

It is important to explicitly work out and record what areas of assessment are difficult to achieve and why.

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

If you feel threatened by the parent or carer, think what life must be like at home for their child/ren.

**The Impact on the Child or Young Person**

The worker needs to be mindful of the impact the hostility to outsiders may be having on the day-to-day life of the child / young person. They may:

Be coping with their situation with hostage-like behaviour;

Have become de-sensitised to violence;

Have learnt to appease and minimise - remember Victoria Climbie always smiled in the presence of practitioners;

Be simply too frightened to tell;

Identify with the aggressor.

The Impact on your Assessment

In order to assess to what extent the hostility of the parents / carers is impacting on your assessment of the child, it may help to ask yourself:

Am I focusing on the needs of the child/ren?

Am I colluding with the parents / carers by avoiding conflict, for example focussing on less contentious issues such as benefits / housing; avoiding asking to look round the house, not looking to see how much food is available; not inspecting the conditions in which the child / sleeps, etc. or, crucially, not asking to see the child / young person alone?

Am I changing my behaviour to avoid conflict? Your behaviour may need to change to adapt to the situation, but the content of what you say and the outcomes you desire should remain unchanged;

Am I filtering out or minimising negative information?

Am I afraid to confront family members about my concerns?

Am I keeping my worries to myself and not sharing risks and assessment with others in the inter-agency network or manager?

Is the child keeping ‘safe’ by not telling me things?

Has the child learned to appease and minimise?

Is the child blaming him or herself?

What message am I giving this family if I don’t challenge?

Am I relieved when there is no answer at the door?

Am I relieved when I get back out of the door?

Did I say / ask / do what I would usually say / ask / do when making a visit or doing an assessment?

Have I identified and seen the key people?

Have I observed evidence of others who could be living in the house, when I have not been told there is anyone else living there?

Is this a case of Domestic Abuse but I am only working with the adult victim?

What might the children have been feeling as the door closed behind me?

**Impact on Multi-Agency Work**

All agencies need to work in partnership with families to achieve the agreed outcome. However, all parties involved need to understand this partnership may not be equal, depending on whether the involvement is with statutory or voluntary agencies.

Sometimes parents / carers 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. 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 / young person unprotected;

The family is ‘punished’ by withholding of services as everyone ‘sees it as a fight’. This is at the expense of assessing and resolving the situation for the child / young person;

There is a divide between those who want to appease and those who want to oppose - or everyone colludes;

Hostility is accepted in order to provide essential services to the child, but other safeguarding needs are overlooked.

When parents / carers are only hostile to some individuals / agencies or where individuals become targets of intimidation intermittently, the risk to good inter-agency collaboration is probably at its greatest. Any pre-existing tensions between agencies and individuals, or misunderstandings about different roles are likely to surface. The risks are that splits occur between the agencies / individuals, with tensions and disagreement taking the focus from the child / young person, for example:

Individuals or agencies blame each other, and collude with the family;

Those not feeling under threat can find themselves taking sole responsibility which can ultimately increase the risk to themselves;

Those feeling ‘approved of’ may feel personally gratified as the family ‘ally’ but then be unable to recognise / accept risks or problems;

Those feeling under threat may feel that it is personal;

There is no unified and consistent plan.

**Ensuring Effective Multi-Agency Working**

Staff should alert other practitioners who know a family to be aware of potential difficulties and risks. Any agency faced with incidents of threats, hostility or violence should routinely consider the potential implications for any other agency involved with the family as well as for its own staff and should alert them to the nature of the risks.

Regular inter-agency communication, clear mutual expectations and attitudes of mutual respect and trust are the core of inter-agency working. When working with hostile or violent parents or carers, the need for good inter-agency collaboration and trust is paramount and is also likely to be put under greatest pressure. It becomes particularly important that everyone is:

Aware of the impact of hostility on their own response and that of others;

Respectful of the concerns of others;

Alert to the need to share relevant information about safety concerns;

Actively supportive of each other and aware of the differing problems which different agencies have in working within these sorts of circumstances;

Open and honest when disagreeing;

Aware of the risks of collusion and of the targeting of specific professions / agencies;

Prepared to discuss strategies if one agency (for example a health visitor) is unable to work with a family - how will information / monitoring be gained and is it possible to have a truly multi-agency plan?

Caution may be needed about how to disclose personal information about certain family members to other services. Concerns about possible repercussions from someone who can be hostile and intimidating may be an added worry. However, information sharing is pivotal in order to safeguard and promote the welfare of children and young people, as is practitioners being explicit about their experiences of hostility, intimidation or violence with named individuals. See Underlying Principles and Values for more information. It is important that you are open and honest with parents, carers and other family members when you have to share information about them with other services. You should tell them what information you are sharing, with whom and for what purpose. However, you should not inform them if so doing would jeopardise the safety of a child or young person, or others.

**Child Protection Conferences, Core Groups and Multi-Agency Meetings**

Avoiding people who are hostile is a normal human response; however it can be very damaging for effective inter-agency work under Child Protection Plans, which depend on proactive engagement by all practitioners with the family. Collusion and splitting between agencies will be reduced by:

Clear agreements, known to all agencies and to the family, detailing each worker’s role and the tasks to be undertaken by them;

Full participation at regular multi-agency meetings, Core Group meetings an at Child Protection Conferences with all agencies owning the concerns for the child rather than leaving it to a few to face the family.

Although it is important to remain in a positive relationship with the family as far as possible, this should not be at the expense of being able to share real concerns about intimidation and threat of violence.

**Options to consider are:**

Discussing with the Child Protection Coordinator the option of using the exclusion criteria if the quality of information shared is likely to be impaired by the presence of threatening adults - see Section 7, Criteria for Excluding Parents or Restricting their Participation of Initial Child Protection Conferences Procedure;

Holding a practitioners meeting to share concerns, information and strategies and to 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 / when to share what has gone on with the family. Secret discussions are unlikely to remain secret, and the aim should always be to empower the Core Group to become more able to be direct and assertive with the family without compromising their own safety;

Holding a meeting to draw up an explicit risk reduction plan for workers and in extreme situations, instituting repeat meetings explicitly to review the risks to workers and to put strategies in place to reduce these risks;

Joint visits with colleagues or workers from other agencies. Police may be involved if necessary;

If workers have experienced a frightening event, debriefing with other agencies, as well as own colleagues, can be helpful.

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

**Responding to Uncooperative Families**

**What Should I Do?**

Unfortunately for the worker making the approach, the underlying feelings of the family may be masked by anger or avoidance, as these parents / carers do not easily trust and may be fearful of closeness. It is best to be practitioner and honest, giving clear indications that the aim of the work is to achieve the best for their child.

It is essential that the parent / carer recognise that you are a practitioner with the authority to be involved with their family. To do this you must clearly state your practitioner authority. The motivations and capacities of the adults to respond cooperatively in the interests of their children, with the help of the worker and their agency will need to be continuously assessed. However, both control and care will be needed, and the worker must confront uncooperativeness when it arises, albeit with understanding and empathy.

You should seek supervision from your manager or advice from senior staff to ensure you are progressing appropriately with the family.

If you are going to be involved over a longer period, you will need to help the parent / carer to work through their underlying feelings as you support them to engage in the tasks of responsible child care.

In some cases, despite making every effort to understand and engage the parents / carers, you may find the family remains completely resistant and will not allow you to become involved. In such cases you should discuss with your manager, and together consider if other action might be necessary. It is important for workers in such situations not to feel a sense of personal failure or practitioner incompetence.

Remember: all workers experience such rebuffs at some point during their working life. There are some families who are resistant despite anyone’s efforts.

**What Should I Not Do?**

Worker’s ‘coping’ strategies that may merely obstruct engagement with any other family can be pitfalls when working with hostile families. As a result perceived or actual harm to the child / young person may be minimised or underestimated by the worker. You will need support to understand the family’s behaviour and your own response to it.

Workers may unknowingly use the following strategies:

See each situation as a potential threat and develop a “fight” response, becoming over-challenging, thus increasing the tension between the worker and the family. This may protect the worker physically and emotionally, or may put them at further risk. It can lead to that worker becoming de-sensitised to the child / young person’s pain and to violence within the home;

Collude with parents / carers by accommodating and appeasing them in order to avoid provoking a reaction;

Become hyper-alert to the personal threat so that you become less able to listen accurately to what the adult is saying, distracted from observing important responses of the child / young person or interactions between the child and adults;

‘Filter out’ negative information or minimise the extent and impact of the child / young person’s experiences, in order to avoid having to challenge. At its extreme, this can result in workers avoiding making difficult visits or avoiding meeting with those adults in their home, losing important information about the home environment;

Feel helpless / paralysed by the dilemma of deciding whether to ‘go in heavy’ or ‘back off’. This may be either when faced with escalating concerns about a child / young person or when the hostile barrier between the family and outside means that there is only minimal evidence about the child’s situation.

**It is important:**

That you make every effort to understand why the family may be uncooperative or hostile, and this entails considering all available information. Find out who else is involved, and contact internal and external colleagues or individuals who have had involvement with the family;

To 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 you want to see them in the office or why you are visiting them at home. They may not be aware of roles that different practitioners and agencies play and may not know 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;

That where you think cultural factors are a factor in a family’s resistance to having practitioners involved, seek expert help and advice in gaining a better understanding of the culture involved. You could 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;

If you anticipate difficulties in engaging with a family, you 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 similarly be underpinned by the need for confidentiality in consultation with the family.

Practitioners need to ensure that clients are treated with respect and dignity at all times. Being practitioner not only involves keeping appointments, and on time, but also ensuring that families are engaged wherever possible and understanding and recognising the impact of cultural differences.

Families may develop a resistance or hostility to involvement if they perceive the worker as disrespectful, unreliable or dishonest, or if they believe confidentiality has been breached outside the agreed parameters.

**Recording Information**

It is vital that, as when working with any family, you make a full record of:

What is said, by whom, when and where;

What you have said;

What action you have taken;

To whom you have referred the child / young person and when;

What they have said to you about the referral and any subsequent action.

All paper based records should be signed, dated, and timed with your contact details. Electronic records should automatically record time, date and who completed them, via user identification numbers used for system logins.

**Chronology**

A Chronology of all concerns relating to a child or young person and their family, dated and sourced, should be recorded in the files of all concerned practitioners. A chronology lists in date order all the major changes and events in a child or young person's life. It can be a useful way of gaining an overview of events in someone’s life. It should be used as an analytical tool to help practitioners understand the impact, both immediate and cumulative, that events and changes may have on the child or young person's developmental progress. This includes non-cooperation of parents / carers.

A chronology should include, for example, changes in the family composition, addresses and any moves, educational establishments and any moves, the child or young person's legal status, any injuries, periods in hospital or other medical treatment, and any disclosure of abuse.

**Dealing with Hostility and Violence**

Despite sensitive approaches by practitioners, some families may respond with hostility and sometimes this can lead to threats of violence and actual violence. It is therefore important to try and understand the reasons for the hostility and the actual level of risk involved. It is critical both for your personal safety and that of the child / young person that risks are accurately assessed and managed.

Threatening behaviour can consist of:

The deliberate use of silence;

Using written threats;

Bombarding workers with emails and phone calls;

Using intimidating or derogatory language;

Racist attitudes and remarks;

Sexualised attitudes and remarks;

Using domineering body language;

Using dogs or other animals as a threat;

Swearing;

Shouting;

Throwing things;

Physical violence;

Use of recording conversations / videos / photographs via computers or mobile phones;

Damaging worker’s property;

Damaging office equipment or property.

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 / carer, it is important that practitioners are aware of the skills and strategies that may help in difficult and potentially violent situations and that they consult their own agency guidance.

**Impact on Workers of Hostility and Violence**

Working with potentially hostile and violent families can place workers under a great deal of stress and can have physical, emotional and psychological consequences. It can also limit what you can allow yourself to believe, make you feel responsible for allowing the violence to take place, lead to adaptive behaviour which is unconsciously “hostage-like”, and also result in distressing physical or psychological symptoms.

The impact on workers may be felt and expressed in different ways, for example:

Surprise;

Embarrassment;

Denial;

Distress;

Shock;

Fear;

Self-doubt;

Anger;

Guilt;

Numbness;

Loss of self-esteem and of personal and/or practitioner confidence;

A sense of helplessness;

Sleep and dream disturbance;

Hyper vigilance;

Preoccupation with the event, or related events;

Repetitive stressful thoughts, images and emotions;

Illness;

Post-traumatic stress.

Factors that increase the impact on workers include:

Previous traumatic experiences, both in practitioner and personal life, can be revived and heighten the fears;

Regularly working in situations where violence and threats are pervasive. Workers in these situations can develop an adrenalin-led response, which may over or under play the threat. Workers putting up with threats may ignore the needs / feelings of other staff and members of the public;

When faced with significant fears for their own safety, workers may develop a ‘hostage-like’ response. This is characterised by accommodating, appeasing or identifying with the ‘hostage-taker’ to keep safe;

Threats that extend to the worker’s life outside of work;

It is often assumed that there is a higher level of risk from men than from women and that male workers are less likely to be intimidated. False assumptions decrease the chances of recognition and support. Male workers may find it more difficult to admit to being afraid, and colleagues and managers may not recognise their need for emotional support. This may be particularly so if the perpetrator of the violence is a woman or young person. In addition, male workers may be expected to carry a disproportionate number of threatening service users;

Lack of appropriate support and a culture of denial or minimising of violent episodes as ‘part of the job’ can lead to the under-reporting of violent or threatening incidents and to more intense symptoms, as the worker feels obliged to deal with it alone;

Violence and abuse towards workers based on their age, race, religion, gender, disability or perceived sexual orientation for example, can strike at the very core of a person’s identity and self-image. If the worker already feels isolated in their workplace in terms of these factors, the impact may be particularly acute and it may be more difficult to access appropriate support;

One worker taking on the role of mediator for the family, in the belief that they are the only practitioner that the family will accept or trust.

**Keeping Workers Safe**

Workers Responsibility

You have a responsibility to plan for your own safety, just as your agency has the responsibility for trying to ensure your safety. Workers 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 procedures on information sharing (both internal and external). Staff and managers need to be aware where further advice can be found.

**Prior to contact with a family consider the following questions:**

Why am I doing this visit at the end of the day when it’s dark and everyone else has gone home?

Risky visits should be undertaken in daylight and in working hours whenever possible;

Should this visit be made jointly with a colleague or a manager?

Is my car likely to be targeted / followed? If yes, it may be better to go by taxi and have that taxi wait outside the house;

Do I have a mobile phone with me or some other means of summoning help (e.g. personal alarm)?

Could this visit be arranged at a neutral venue?

Are my colleagues / line managers aware of where I am going and what time I should be back? Do they know that I may be particularly at risk during this visit?

Are there clear procedures for what should be done if an officer does not return or report back within the agreed time from a home visit?

Does my manager know my mobile phone number and network, my car registration number and my home address and phone number?

Do my family members know how to contact someone from work if I don’t come home when expected?

Have I taken basic precautions such as being ex-directory at home and having my name removed from the public section of the electoral register?

Have I accessed personal safety training?

Is it possible for me to continue to work effectively with this family?

If threats and violence have become a significant issue for a worker, their line manager should consider how the work could safely be progressed; document their decision and the reasons for this.

**Finally, a few Don’ts**

Don’t take it personally;

Don’t get angry yourself but be firm in your requirements;

Don’t be too accommodating and understanding;

Don’t assume you have to deal with it and then fail to get out;

Don’t think that you don’t need strategies or support;

Don’t automatically assume it’s your fault and that if you had said or done something differently it wouldn’t have happened;

Don’t put personal information about yourself on social networking sites,

Don’t give your personal contact details, such as email address or mobile phone number to families; always give work details.

**Management Responsibility**

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

Undertaking assessments to identify and manage the risks inherent in all aspects of the work;

Providing a safe working environment;

Providing adequate equipment and resources to enable safe working;

Providing specific training to equip workers with the necessary information and skills to undertake the job;

Ensuring a culture that allows workers to express fears and concerns and in which support is forthcoming without implications of weakness.

Managers need to ensure:

Workers are aware of any home visiting policies employed in their service area and that these policies are implemented;

Planning time is allowed e.g. to obtain sufficient background information and plan contact; agree safety strategies with manager;

Strategies and support are in place to deal with situations that arise;

They are mindful of the skills and expertise of their team. They need to seek effective and supportive ways to enable new workers, who may be inexperienced, to identify and develop the necessary skills and expertise to respond to uncooperative families;

Similarly, more experienced staff may become desensitised and may make assumptions about families and situations;

Awareness of the impact of incidents on other members of the team;

Where an incident has occurred, managers need to try to investigate the cause e.g. whether this was racially or culturally motivated;

Awareness that threats of violence constitute a criminal offence and that the agency must take action on behalf of staff i.e. make a complaint to the Police;

Pro-actively ask about feelings of intimidation or anxiety so that workers feel that this is an acceptable feeling.

For more information, see Ten pitfalls and how to avoid them- What research tells us.

**Supervision and Support**

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

Managers must encourage a culture of openness, where their workers 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 their 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 workers. Some agencies have confidential staff support systems, which involve sympathetic listeners. Managers should ensure that staff know how to access such support.

Workers 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 practitioner should prepare for supervision and should 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 practitioner 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 workers and mechanisms to alert other colleagues to potential risks should be clearly visible on case files.

**Visiting Prisons**

**Introduction and Duties of Prison Governors**

The National Offender Management Service Agency Board has set out a range of measures to reduce the risks that certain prisoners, especially those convicted of, or charged with offences against children, may present to children whilst in prison.

Governors of prisons have a duty to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children and vulnerable adults.

Prison staff and those working in visitors' centres should receive training, briefing or guidance as appropriate in safeguarding and child protection that is proportionate to the likely level of contact with children, in order for them to take appropriate action if concerns are raised during a visit. The establishment - or the service provider - should arrange specific safeguarding and child protection training - rather than safeguarding awareness training - for Family Support Workers, Play Supervisors and Visitor Centre staff who supervise activities for children.

Working Together to Safeguard Children 2015 states:

Para 28.

The Prison Service is subject to the section 11 duties set out in paragraph 4 of chapter 2 WT. It also has a responsibility to identify prisoners who pose a risk of harm to children. Where an individual has been identified as presenting a risk of harm to children, the relevant prison establishment:

Should inform the local authority children’s social care services of the offender’s reception to prison and subsequent transfers and of the release address of the offender;

Should notify the relevant probation service provider. The Police should also be notified of the release address; and

May prevent or restrict a prisoner’s contact with children. Decisions on the level of contact, if any, should be based on a multi-agency risk assessment. The assessment should draw on relevant risk information held by Police, probation service provider and prison service. The relevant local authority children’s social care should contribute to the multi-agency risk assessment by providing a report on the child’s best interests. The best interests of the child will be paramount in the decision-making process.

Para 29.

A prison is also able to monitor an individual’s communication (including letters and telephone calls) to protect children where proportionate and necessary to the risk presented.

Para 30.

Governors/Directors of women’s prisons which have Mother and Baby Units should ensure that:

There is at all times a member of staff on duty in the unit who is proficient in child protection, health and safety and first aid/child resuscitation; and

Each baby has a child care plan setting out how the best interests of the child will be maintained and promoted during the child’s residence in the unit.

See also Providing Visits and Services to Visitors 2014/15.

**Definition of Contact**

Contact with a child includes correspondence, prisoner’s telephones, any contacts via the internet including social media and mobile phone texting and social visits.

Telephone contact will include any access to office telephones or computer usage, where permission has been granted. It will also include any contact with children who have been invited to visit the prison as part of a group.

**Contact Requests**

Prison Rules require prisons to actively encourage prisoners to maintain outside contacts and meaningful family ties. This is integral to the prisoner’s Right to Family Life as well as their rehabilitation. Visits are seen as crucial to sustaining relationships with close relatives, partners and friends, where appropriate, and help prisoners maintain links with the community.

Prison Rules 34 and 73 (1) /YOI Rules 9 and 77 allow the Governor discretion to refuse a social visit or determine the conditions under which it takes places. Such a decision must be necessary for one of the purposes specified in the Rules and should be proportionate to the objective being pursued. These criteria reflect the requirements of Article 8 of the European Convention on Human Rights.

If a prisoner wishes to apply to have child contact, the Prison staff must provide an application form for the prisoner to complete for a Visiting Order. A separate request must be made for contact with each individual child.

It is possible that a request for contact could be made by a parent or from the child directly. If such a request is received the prisoner will be informed and asked if s/he wishes to submit a request for contact.

A register providing a record of applications must be held on file. This record will become part of the prisoner’s main record and will follow the prisoner on transfer. Each prison establishment should maintain a central record indicating which prisoners are subject to restrictions due to the risk they represent to children, details of which prisoners are allowed child visits or other contact and details of prisoners who have been refused child visits or other contact.

**Parental Support for Contact**

The prison establishment should ask the parent of the child whether they support contact. Children’s Social Care Services for the area where the child is living should ascertain the wishes and feelings of the child during a home visit. For the visit to take place, Children’s Social Care Services must also ascertain that the person who has Parental Responsibility and is currently caring for the child supports any contact.

In cases where the parent does not support contact, the prison establishment should inform Children’s Social Care Services of the parent’s decision.

**Looked After Children**

When a prison establishment contacts Children’s Social Care Services as part of the multi agency assessment and the child is Looked After, the local authority’s view about the appropriateness of contact must be obtained in writing. The test is always whether contact is in the child’s best interest.

Whether or not the local authority share Parental Responsibility, the views of the parent must also be included.

**The Multi Agency Assessment**

In order for the prison establishment to undertake the risk assessment to determine the risk to which a child might be exposed and the risk that a prisoner presents, it must contact and gather information from a range of agencies:

The Police in the child’s home authority must be contacted with details of the prisoner and the child including a photograph;

The prison establishment’s probation officer should be provided with the details of the prisoner’s application and where a prisoner will be subject to licence supervision on release or has been recalled for breach of licence for the current offence the home National Probation Service provider must be contacted and asked for information and comments. In addition if the prisoner is a young offender and is supervised, Children’s Social Care Services in the child’s home authority must be contacted;

Where appropriate the NSPCC may be contacted for additional information as some prison establishments have developed a partnership with the NSPCC who will search their database for information relating to the risk of harm to a child;

A letter to the Head of Children’s Social Care Services including all known details of the prisoner and the child with a photograph must be followed up with a prompt phone contact to the Safeguarding Manager in the Children’s Social Care Services.

The Safeguarding Manager will acknowledge the request in writing to the prison establishment within 2 working days and the Safeguarding Unit will process it by:

Checking any information across all electronic and manual records held by Children’s Social Care Services; and

Establishing which Children’s Social Care Services Team is responsible for the child(ren) involved;

Within one working day of receipt of the prison request, the Safeguarding Manager will notify the relevant Children’s Social Care Services Team who will action an assessment and respond with a report to the Safeguarding Unit within 10 working days. The views of the child should be an important element of the assessment;

The Safeguarding Manager will forward the Assessment Report with recommendations to the prison establishment within 2 working days of receiving it from the Children’s Social Care Services team.

**The Decision**

The operational manager with delegated authority in the prison establishment, normally the Head of Resettlement or through care, who has responsibility for Public Protection, will make the assessment using the available multi agency information. The decision must take into account the following factors:

The child’s needs, wishes and feelings;

The capacity of the parent to protect the child from significant harm;

The prisoner’s risk to the public;

Pre-sentence reports;

Previous convictions;

Custodial behaviour and any other documentation highlighting risk.

**Level of Contact Decided**

The operational manager should decide the level of contact that will be permitted. It should be proportionate to the risk identified and the best interests of the child should always be the overriding principle in making these decisions.

Contact restrictions should be incremental and one of the following levels will be applied:

Level one: Full restrictions apply. No contact with any child is permitted and all correspondence and telephone calls will be monitored;

Level two: Contact is only permitted via written correspondence. All correspondence and telephone calls will be monitored;

Level three: Contact is permitted via written correspondence and telephone. All correspondence and telephone calls will be monitored;

Level four: No restrictions necessary. May have contact via correspondence, telephone, visits and family visits. Routine sampling applies –reading of correspondence, listening to telephone calls, general observation in visiting area.

**Monitoring**

The level and frequency of monitoring will be proportionate to the risk identified. Monitoring should focus on whether the prisoner is attempting to contact children inappropriately and what references about children are made in general correspondence i.e. grooming or manipulation of a child or a parent.

Monitoring of prisoners who present a risk to children in the visits area is required to establish if appropriate contact is taking place between an offender and a child where child visits have been permitted. Other prisoners who present a risk to children and have not been permitted contact with a child must be supervised in such a way that contact is not possible.

Recorded e.g. audio cassettes, CDs and VideoCDs, and electronic information, including any internet, social media or text messaging access, needs to be monitored because it affords an easy disguise for inappropriate information.

**Correct Identification of Children**

It is necessary to take steps to prevent a child being substituted with another possibly more vulnerable child where visits take place. Prison staff monitoring calls, correspondence and visiting areas need to be vigilant and prevent any inappropriate contact where identified.

Four passport style photographs will be required of each child and these should be updated annually or earlier if there is a significant change in a child’s appearance.

**Reviewing Contact Decisions**

Where a decision has been made to restrict contact, the decision will be reviewed when there is reason to believe that circumstances have changed. Reviews can be made at any time on the initiative of prison staff or at the request of the prisoner. It is good practice to review decisions every six months.

Any decision to change the level of contact permitted must be based on what is best for the child. The child’s welfare is paramount at all times. The decision must take into account the views of the Police, Probation and local Children’s Social Care Services, via the LA Safeguarding Unit.

**Appeals Process**

All prison establishments have procedures for prisoners who wish to appeal a decision to restrict contact or not to permit any contact at all with a child.

If the prisoner wishes to challenge the information held on file, the information provided by other agencies should only be disclosed to the prisoner with the agreement of the other agency.