Safeguarding Children

CHILD PROTECTION AWARENESS

Foundation Level

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Diversity Issues in the Training Setting

People who present courses for Reconstruct make some assumptions, even though we're supposed not to, about participants.

These are that the group will contain people from a diverse range of backgrounds, some visible some less visible, some personal some professional. This diversity will cover gender, race, sexual orientation, disability and a lot more including personal experiences, class and religious persuasion.

So this means that the course will

- be presented using variety because people have different learning styles,
- describe concepts using a variety of examples.

The presenters will

- avoid jargon (or at least explain it),
- be aware of individual differences within the group and respect these,
- avoid the stereotyping of particular groups in society,
- be aware of the effect of language,
- accept that everyone has the right and the responsibility to challenge.

Additionally the facilitators hope that participants will:

- arrive punctually and stay (but explain unavoidable absences),
- respect each other,
- maintain the confidentiality of sensitive information,
- recognise and value difference,
- share experiences,
- ask questions,
- challenge views constructively.

We hope that this will provide a useful framework within which learning and development can take place.

What is Abuse and Neglect?

Definitions of abuse:

Child abuse is any act that impedes or deprives a child of reaching their full potential, whether by an individual or the state.

GIL, D. 1975

Child abuse consists of anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospects of a safe and healthy development into adulthood.

The National Commission of Inquiry into the Prevention of Child Abuse 1996

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults or another child or children.

Working Together to Safeguard Children 2006

Categories of Abuse:

Physical abuse
Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.

Emotional Abuse
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child,
though it may occur alone.

Sexual Abuse
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision including the use of inadequate care-takers, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Working Together to Safeguard Children 2006, HM Government

Potential Risk Indicators of Abuse:

This is not an exhaustive list but highlights some common signs and symptoms, some may appear in more than one category of abuse

Physical Abuse	Neglect
Unexplained injuries or burns Improbable excuses Untreated injuries Repeated admissions to casualty Flinching or withdrawing from contact Arms and legs covered in hot weather Fear of returning home Self harming Running away Fabricated or factitious illness Fire setting	Constant hunger/constant tiredness Poor personal hygiene Clothing inappropriate for weather/ poor state of clothing Emaciated/malnourished Frequent lateness at school Non attendance at school Untreated medical problems Repeated failure to attend appointments Poor social relationships Stealing or scavenging for food Poor sense of identity Low self esteem

Emotional Abuse	Sexual abuse
Physical, emotional and developmental delay Speech/eating disorders Low self esteem Excessive punishment by carers Over reaction to mistakes Fear of new situations Neurotic behaviour Self harming Fear of parents/adult Extremes of passivity/aggression Drug/solvent/alcohol abuse Running away Stealing Bedwetting/soiling Cruelty to animals	Emotional distress/incongruent behaviour Inappropriate sexual knowledge or behaviour for age Eating disorders Fear of specific adult/men Mental illness/depression Alcohol/drug abuse Unexplained amounts of money Running away Bruise marks on inner thighs/upper arms Chronic throat infections/herpes Bedwetting/soiling Contact with known offenders Fear of dark/nightmares Poor sleeping Pregnancy

Children on child protection registers at 31 March 1995–2005

1 Out of a total of 552,000 referrals to social services departments, 121,800 (22%) were repeat referrals that had previously been made within the last year. This compares with 127,400 (22%) out of a total of 572,700 in the year ending 31 March 2004. This year has seen a drop in the number of referrals. In recent years the number of referrals has remained fairly stable at around 570,000.

2 Of the 290,300 initial assessments completed in the year, 179,200 (62%) were completed within 7 working days of referral. This compares with 169,100 (58%) out of a total of 290,800 for the previous year.

3 Of the 74,100 core assessments undertaken in the year, 49,700 (67%) were completed within 35 days (PAF C64). This compares with 39,400 (62%) out of a total of 63,600 for the previous year

4 There were 25,900 children on child protection registers at 31 March 2005, 1% fewer than a year earlier and 26% fewer than in 1995

5 The 2005 figure represents 23 children per 10,000 of the population aged under 18 compared with 24 last year. This compares with 27 children per 10,000 of the population aged under 18 for 5 years ago and 32 children per 10,000 in 1995.

6 There were 30,700 additions to the registers during the year ending 31 March 2005 and 31,100 children were de-registered over this same period. This was a decrease of 2% for registrations and a decrease of 1% for de-registrations in comparison with the previous year.

7 13% of children registered during 2004–05 had previously been registered – the same percentage as 2003–04. This compares with 14% five years ago.

8 3,000 (12%) of the children on the register at 31 March 2005 were also looked after by local authorities. This compares with 3,400 (13%) last year. Five years ago 5,400 (20%) children on the register were looked after.

9 79% of looked after children who were on registers were in foster placements and 13% were placed with their own parents. These percentages are exactly the same as in 2004 but differ from five years ago when 72% of looked after children were in foster placements and 18% were placed with their own parents.

10 43% of registrations related to children considered to be at risk of neglect. Emotional abuse accounted for 19% of registrations followed by physical abuse (18%) and sexual abuse (9%). Mixed categories made up the remaining 12%. With the exception of “neglect” (which have increased from

39% to 43% of all registrations) these proportions have generally been consistent for the last 4 years.

11 6% of children removed from the register had been on it for over 2 years – this compares with 7% for the previous year, 11% five years ago and 17% in 1995.

12 99% of child protection cases which should have been reviewed during the year were reviewed . This compares with 95% of all cases for 2003–04 and 87% for the period 2000–01.

Reference:
Referrals, Assessments and Children and Young People on Child Protection Registers:Year Ending 31 March 2005
http://www.dfes.gov.uk/rsgateway/DB/VOL/v000632/VOL01-2006textv1.pdf

Key information on fractures and bruising:

The information below is based on a systematic review of all the quality work in the world literature about abusive fractures in children; full details are available at www.core-info.cf.ac.uk

Fractures are a normal part of growing up
Accidental fractures are common in children: up to 66 per cent of boys and around 40 per cent of girls will sustain a fracture by their 15th birthday. 85 per cent of accidental fractures are seen in children over five years of age. However, they can also be indicative of abuse or a serious assault on a child.

What do we know about fractures in child abuse?
Fractures occur in up to 25 per cent of physically abused children; 80 per cent of these fractures are in children under 18 months. Any bone in the body can be broken as a result of child abuse. Many abusive fractures are not clinically obvious unless x-rays are taken, especially in infants under two years. Fractures, particularly rib fractures, may not be accompanied by bruising.

How do you know if a child has a fracture?
Fractures in very young children may only be revealed by x-ray or other radiological tests. They may not be obvious even on x-ray immediately after the injury; they are easier to identify once the bones show some signs of healing.

How do you find the fractures?
Abused children frequently have multiple fractures and these may be of different ages. Where physical abuse is suspected, specialised x-rays should always be taken of children under two years and may need to be taken of some older children. Two types of x-ray may be used.

Skeletal survey
This is a series of plain x-rays of all the bones in the body; although acute rib fractures and metaphyseal fractures are particularly difficult to see and may require a repeat skeletal survey 10–14 days later which may show healing fractures not originally visible.

Radionuclide bone scan
A radionuclide bone scan is a specialised x-ray which is particularly good at detecting recent fractures and may show additional fractures not evident on the skeletal survey. However, a bone scan will miss skull fractures and may miss metaphyseal fractures.

It is advisable to perform both as either test may miss different fractures,

Can you tell how old a fracture is?
Radiologists can only estimate the age in weeks, not days and dating of fractures in abused children can be difficult if:

- no accurate description of the cause or timing of the injury has been given
- further injury to an already broken bone occurs
- the bone has not been immobilised, which may alter the rate of healing.

When should you be concerned that a child may have been abused?
The following apply in the absence of organic bone disease.

- Rib fractures are highly indicative of abuse in children who have not been in a major accident.
- A femoral fracture in a child who is not walking can be suggestive of abuse.
- A spiral fracture is the commonest fracture of the femur in abused children younger than 15 months; in all other age groups, a transverse fracture is the commonest accidental or abusive femoral fracture.
- Metaphyseal fractures of the femur in very young children are more likely to be due to abuse than accidental causes.
- A humeral fracture has a one-in-five chance of arising from abuse, but a supracondylar fracture is highly suggestive of accidental injury.
- Up to a third of complex skull fractures may be as a result of abuse.
- Multiple fractures are frequently seen in abused children; these may show different stages of healing.

Fractures may occur to the vertebrae, pelvis, hands and feet, scapula, clavicle and first rib. Skeletal surveys and bone scans should take care to exclude the possibility of such fractures.

Implications for practice
A fracture, like any other injury, should never be interpreted in isolation. It must always be assessed in the context of the child's medical and social history, developmental stage and explanation given. In the following situations there should be a careful evaluation to exclude child abuse:

- children under 18 months with a fracture
- children whose fracture is inconsistent with their developmental stage
- multiple fractures, particularly of different ages, in the absence of an adequate explanation
- rib fractures in children with normal bones and no history of major accidents
- a fractured femur in a child who is not yet walking.

Should all brothers and sisters of an abused child have a skeletal survey?
The risk to each child must be assessed, and decisions regarding skeletal surveys taken accordingly.

Glossary:

Complex skull fracture This is variously defined as:

- a depressed fracture where the skull is pushed in
- two or more fractures of the skull
- fractures that cross the sutures (natural joining edges of skull bones) or those that are widening.

Metaphyseal fracture Also known as a *bucket handle*, *chip* or *corner fracture*, this occurs at the growing end of the bone and only in children. Recent fractures are very difficult to see but become more obvious after 11 to 14 days. They are thought to happen when the baby has been pulled or swung violently and the relatively weaker growing point of the bone breaks, although there may be no outer sign of a fracture. They may occur accidentally following birth injuries, or
physiotherapy to neonates.

Radionuclide dye This is a radioactive dye that the body disposes of rapidly and causes no harm. On a radionuclide bone scan a *hot spot* is an area of bone where more dye is taken up than expected. This may be due to a fracture, which would then be confirmed with a conventional x-ray.

Spiral fracture This refers to the direction in which the bone is fractured. It implies that there has been a twisting force to cause the fracture. Spiral fractures can also occur accidentally in the femur once the child is walking.

Supracondylar fracture of humerus This refers to a fracture of the upper arm, immediately above the elbow.

Transverse This is a straight-line fracture across the bone.

Produced by the Welsh Child Protection Systematic Review Group: a collaborative project between the Department of Chidl Health, Cardiff University and the NSPCC

What do we know about bruising?

Once children are mobile they sustain bruises from everyday activities and accidents. Bruising in a baby who is not yet crawling is very unusual. It is rare for infants who are starting to walk by holding on to the furniture to have bruises but most children who are walking independently will have bruises. Bruises usually happen when children fall over or bump into objects in their way and children have more bruises during the summer months.

Where would you expect to see bruising from an accidental injury?

• The shins and the knees are the most likely places where children who are walking, or starting to walk, get bruised.
• Most accidental bruises are seen over bony parts of the body, eg knees and elbows, and are often seen on the front of the body.
• Infants who are pulling to stand may bump and bruise their heads, usually the forehead.
• Fractures are not always accompanied by bruises.

When should you be concerned?

There are some patterns of bruising suggestive of physical abuse.

- Abusive bruises often occur on soft parts of the body, eg cheeks, abdomen, back and buttocks.
- The head is by far the commonest site of bruising in child abuse.
- Clusters of bruises are a common feature in abused children. These are often on the upper arm, outside of the thigh, or on the body.
- As a result of defending themselves, abused children may have bruising on the forearm, face, ears, abdomen, hip, upper arm, back of the leg, hands or feet.
- Abusive bruises can often carry the imprint of the implement used or the hand.
- Non-accidental head injury or fractures can occur without bruising.

Can you age a bruise accurately?

The answer is **no**. Estimating the age of a bruise based on an assessment of the colour of the bruise has about a 50 percent accuracy rate. It is not possible to accurately age a bruise from an assessment of colour – from either a clinical assessment or a photograph.

Implications for practice

Don't interpret a bruise should in isolation, look at the context of the child's medical and social history, developmental stage and explanation given.
Bruising that suggests the possibility of physical child abuse includes:

- bruising in children who are not independently mobile
- bruising in babies
- bruises that are seen away from bony prominences
- bruises to the face, back, abdomen, arms, buttocks, ears and hands
- multiple bruises in clusters
- multiple bruises of uniform shape
- bruises that carry an imprint – of an implement or cord.

Vulnerable Children

As many as 1 in 4 children suffers from depression or other mental health problems, children who are looked after are especially vulnerable. A high proportion of children admitted to psychiatric hospitals have been sexually abused. *The Mental Health of Children looked after by local authorities in England: [2003]* Office of National Statistics. The Stationery Office www.statistics.gov.uk

Children living in institutions are more vulnerable to sexual abuse, including children with learning difficulties or disabilities
Children with multiple disabilities are more vulnerable to severe sexual abuse by more than one abuser
Black children are over represented in the care system and in prison statistics
Progress *on safeguards for children living away from home'* Joseph Rowntree Foundation www.jrf.org.uk/pressroom/releases/151104.asp

Learning difficulties and severe behaviour problems may be caused by emotional abuse or neglect
For a helpful paper on recent government statistics: http://www.statistics.gov.uk/pdfdir/cmd0805.pdf

The impact of witnessing domestic violence can be as severe as experiencing the abuse in person and can have long term consequences for children
http://www.homeoffice.gov.uk/rds/violencewomen.html

Many young care leavers, boys and girls, end up in prison or on living on the streets where they are very vulnerable to exploitation
The Commercial Sexual Exploitation of Children and Young People: An Overview of Key Literature and Data . The Thomas Coram Research Unit 2004, http://www.acpc.gov.uk/tcrucsereview.pdf)

The Abuse of Disabled Children

The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Disabled children may be especially vulnerable to abuse for a number of reasons.

Some disabled children may:

- have fewer outside contacts than other children;
- receive intimate personal care, possibly from a number of carers, which may both increase the risk of exposure to abusive behaviour, and make it more difficult to set and maintain physical boundaries;
- have an impaired capacity to resist or avoid abuse;
- have communication difficulties which may make it difficult to tell others what is happening;
- be inhibited about complaining because of a fear of losing services;
- be especially vulnerable to bullying and intimidation; and/or
  be more vulnerable than other children to abuse by their peers.

Safeguards for disabled children are essentially the same as for non disabled children. Particular attention should be paid to promoting a high level of awareness of the risks of harm and high standards of practice, and strengthening the capacity of children and families to help themselves including:

- making it common practice to help disabled children make their wishes and feelings known in respect of their care and treatment;
- ensuring that disabled children receive appropriate personal, health, and social education (including sex education);
- making sure that all disabled children know how to raise concerns, and giving them access to a range of adults with whom they can communicate. Those disabled children with communication impairments should have available to them at all times a means of being heard;
- an explicit commitment to, and understanding of disabled children's safety and welfare among providers of services used by disabled children;
- close contact with families, and a culture of openness on the part of services; and
- guidelines and training for staff on good practice in intimate care; working with children of the opposite sex; handling difficult behaviour; consent to treatment; anti-bullying strategies; and sexuality and sexual behaviour among young people, especially those living away from home.

Where there are concerns about the welfare of a disabled child, they should be acted upon, in the same way as with any other child. Where a disabled child has communication impairments or learning disabilities, special attention should be paid to communication needs, and to ascertain the child's perception of events, and his or her wishes and feelings. Children's social care and the police should be aware of nonverbal communication systems, when they might be useful and how to access them, and should know how to contact suitable interpreters or facilitators. Agencies should not make assumptions about the inability of a disabled child to give credible evidence, or to withstand the rigours of the court process. Each child should be assessed carefully, and helped and supported to participate in the criminal justice process when this is in the child's best interest and the interests of justice.

Working Together to Safeguard Children 2006

CHILDREN ACT 1989

PART III: LOCAL AUTHORITY SUPPORT FOR CHILDREN AND FAMILIES

SECTION 17: Provision of Services for Children and Their Families

1. It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part):

    a. to safeguard and promote the welfare of children within their area who are in need; and

    b. so far as is consistent with that duty, to promote the upbringing of such children by their families

    by providing a range and level of services appropriate to those children's needs

A child is in need if:

a) He is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority;

b) His health or development is likely to be significantly impaired or further impaired without the provision for him of such services; or

c) He is disabled

SECTION 47

1) Where a local authority:

    a) are informed that a child who lives, or is found, in their area:

        i. is the subject of an emergency protection order, or
        ii. is in police protection, or

    b) have reasonable cause to suspect that a child who lives or is found in their area, is suffering, or is likely to suffer, significant harm,

the Authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare

The law is supplemented by **Working Together to Safeguard Children 2006** which provides advice and guidance on inter-agency co-operation for all those who work with children and their families and lays down the roles and responsibilities of all key agencies in conjunction with the Local Safeguarding Children's Boards.

Is the child suffering or likely to suffer harm?

If so, how?

Ill-treatment OR Impairment of health OR Impairment of development

Physical, mental, sexual

Physical or mental

Physical, emotional, behavioural, intellectual or social

Compared with what could reasonably be expected of a similar child

IS IT SIGNIFICANT?

If significant is it attributable to

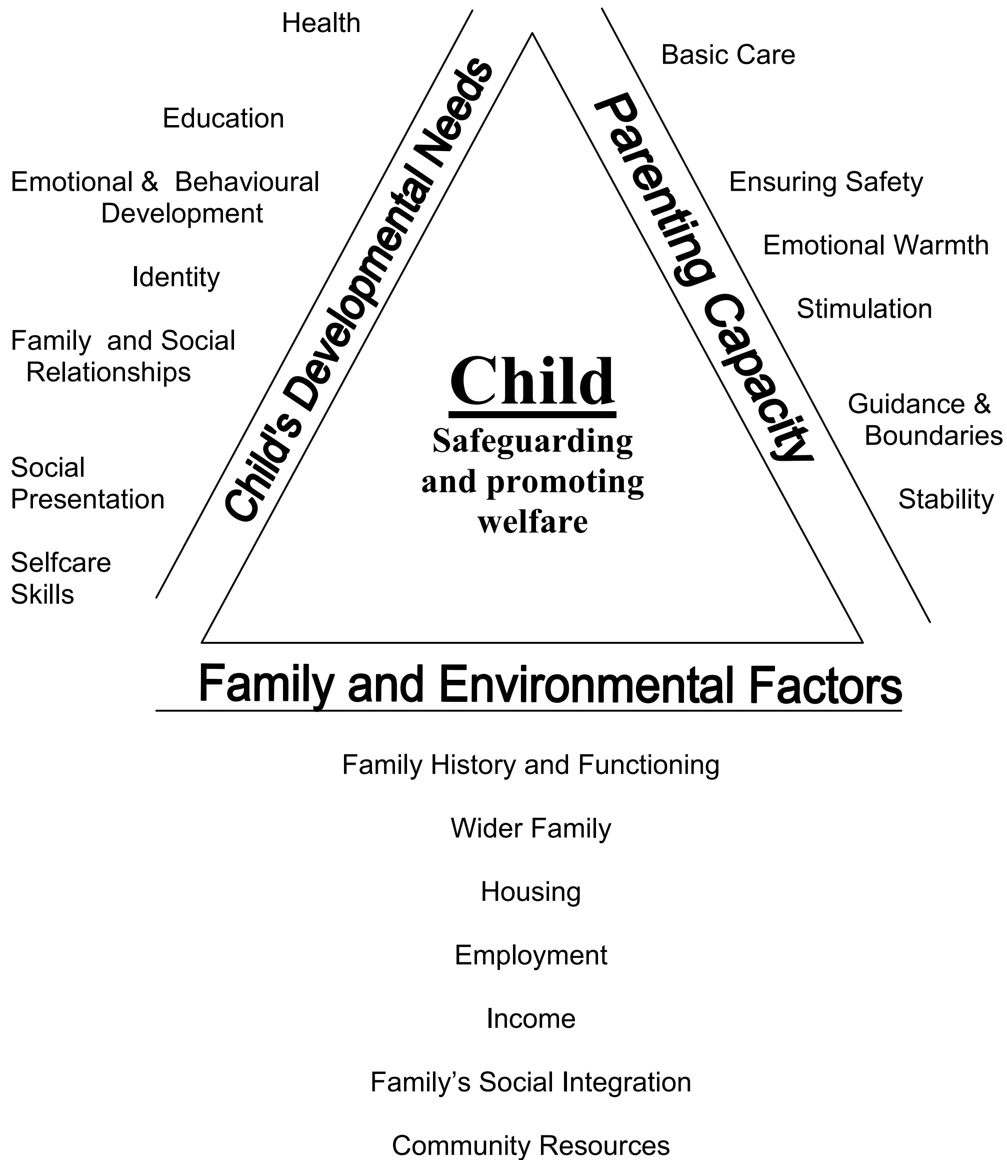
Care given

Care likely to be given

The child being beyond parental control

NOT WHAT IT WOULD BE REASONABLE TO EXPECT A PARENT TO GIVE TO THE CHILD

Assessment Framework Triangle



Family History and Functioning

Wider Family

Housing

Employment

Income

Family's Social Integration

Community Resources

Assessing causes for concern where cultural differences are an issue

Do the adults in the family see the cause for concern as a cultural norm?

Do they want change?

Does the child see the cause for concern as a cultural norm?

Does the child want change?

Does the community see the cause for concern as an acceptable cultural norm?

Are there organisations / people within the community trying to affect change?

Is there evidence that the cause for concern will cause significant harm to the child?

Is the cause for concern illegal?

Original model produced by All Equal Under The Act, Race Equality Unit.

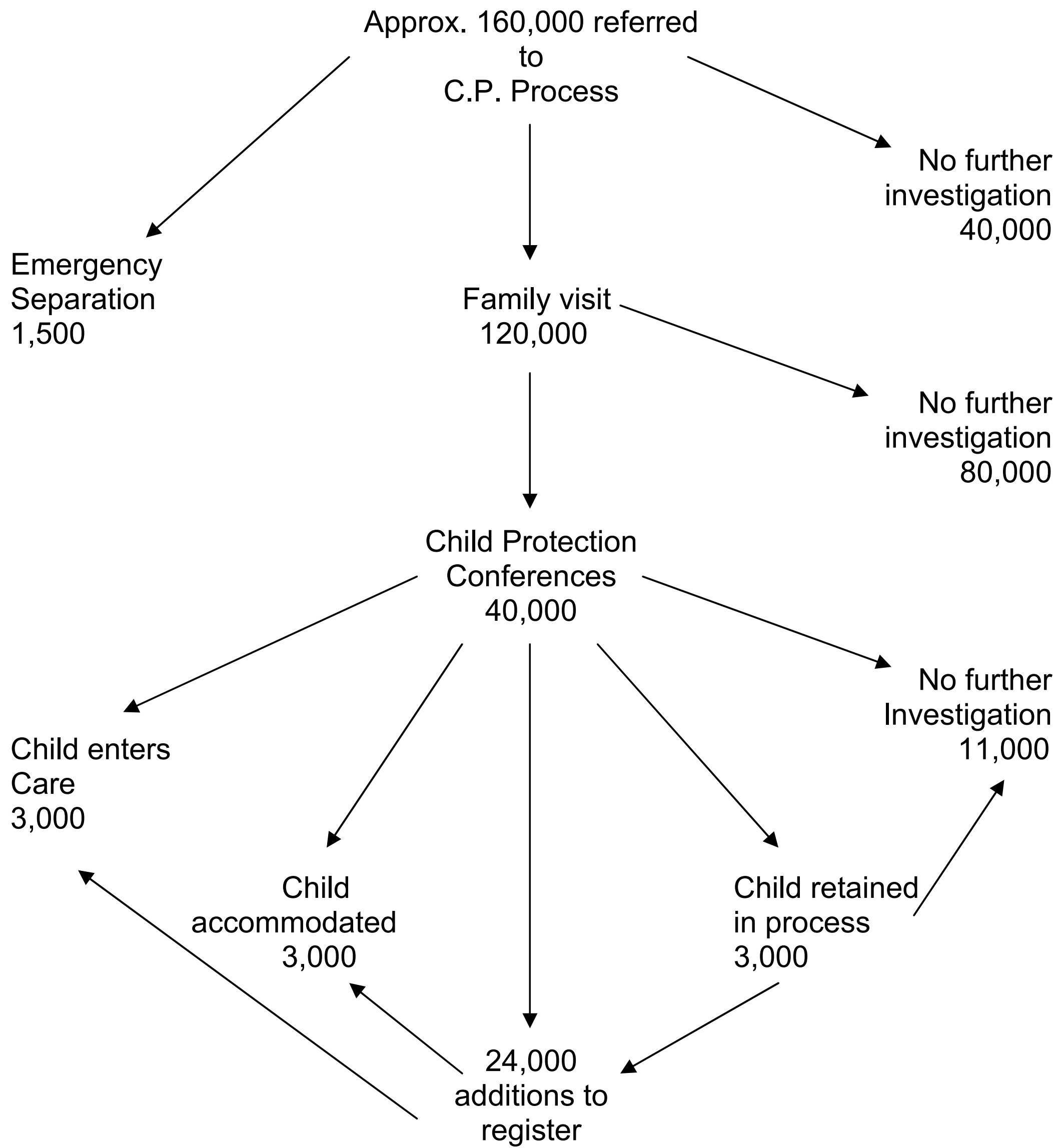
Professional Judgment:

All child care workers will find themselves, to some extent, maintaining a difficult balancing act where they have to consider:

- ☐ The welfare of the child and their rights under Article 12 of the UN Convention on the Rights of the Child and the Children Acts 1989 & 2004
- ☐ The responsibility of the parents, including their right to a private life under Article 8 of the Human Rights Act
- ☐ The legal requirements, procedures and guidance (Children Act 1989, Working Together 2006, Data Protection Act etc.)
- ☐ Own professional responsibilities and codes of conduct
- ☐ Our own personal feelings and experiences
- ☐ Our professional and (personal) rights to be safe and supported
- ☐ Accurate assessments and sound decisions based on factual information reliable research and evidence based practice
- ☐ Not to further abuse the child / young person through the child protection systems

THE CHILD PROTECTION PROCESS

11 Million Children in England



taken from Messages From Research 1995

Dealing with Confidential Information

If a child chooses to confide in you, they probably see you as a trustworthy person

But – don't promise to keep secrets

Explain in simple words that if you are told something that affects a child's welfare or safety you may have to share that information with someone else

It is much better to say this before a child tells you something confidential than after – the words can't be unsaid

Some children may choose not to tell you anything even if they are in a risky situation; you may have to accept this but continue to offer support

Don't go into too much detail: what happened, where, when and who was involved are the key bits of information needed

Listen carefully and make a record of what you asked and what was said by the child:

Include observations of behaviour
Any recent changes

Try not to let your own emotions take over, but don't appear cold and uncaring

Always explain what you will do next and keep the child informed of what is happening

A Child's Right to Self Protection

To be safe:
Children have the same basic rights as everyone else, which should not be taken away. No-one should take away their right to be safe.

To protect their own bodies:
Children need to learn that their body belongs to them, particularly their private parts.

To say No!!
It is alright to say no to any person who tries to hurt or harm them (but not when asked to do their homework etc.)

To tell
Assure your children that no matter what happens you will not be angry with them and that you want them to tell you of any incident. Children can be protective of parents and may not want to tell them of incidents in order to protect them.

To be listened to:
When children are taught to ask adults for help they need to know they will be listened to and supported.

Not to keep secrets:
Secrets can be difficult.
Children are encouraged to keep secrets, birthday surprises etc.
Abusers can and will use this to hide abuse.
Adults need to give clear messages about unsafe secrets.

To refuse touches:
Children need to be taught that they can say yes or no to touches or kisses from anyone.

Not to talk to strangers:
It is never a good idea to talk to strangers.
Well meaning adults or adolescents do not approach children unless they are lost or in distress.
Have an agreement on what to do if they get lost.

Breaking Rules
Children need to be given permission to break rules to protect themselves, i.e. runaway, yell, create a fuss even to tell a lie or kick or punch to get away from danger.

Safeguarding Children: What to do if you suspect a child is being abused

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

- you may have concerns about a child, and refer those concerns to social services or the police (via your designated teacher in the case of staff in schools);
- you may be approached by social services and asked to provide information about a child or family or to be involved in an assessment or to attend a child protection conference. This may happen regardless of who made the referral to social services (for more about sharing information, see the appendix, which explains how you should share information in order to safeguard children);
- you may be asked to carry out a specific type of assessment, or provide help or a specific service to the child or a member of their family as part of an agreed plan and contribute to the reviewing of the child's progress (including attending child protection conferences).

The flow charts illustrate the processes for safeguarding children:

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

EVERYONE WORKING WITH CHILDREN AND FAMILIES SHOULD…

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

- When referring a child to social services, you should consider and include any information you have on the child's developmental needs and their parents'/carers' ability to respond to these needs within the context of their wider family and environment. Similarly, when contributing to an assessment or providing services, you should consider what contribution you are able to make in each of these three areas. Specialist assessments, in particular, are likely to provide information in a specific dimension, such as health, education or family functioning.
- Communicate with the child in a way that is appropriate to their age, understanding and preference. This is especially important for disabled children and for children whose preferred language is not English. Where concerns arise as a result of information given by a child, it is important to reassure the child but not to promise confidentiality.
- See the child as part of considering what action to take in relation to concerns about the child's welfare.
- Record full information about the child, at first point of contact, including name(s), address(es), gender, date of birth, name(s) of person(s) with parental responsibility (for consent purposes) and primary carer(s), if different, and keep this information up to date. In schools, this information will be part of the pupil's record.
- Record all concerns, discussions about the child, decisions made, and the reasons for those decisions. The child's records should include an up-to-date chronology, and details of the lead worker in the relevant agency – for example, a social worker, GP, health visitor or teacher.

IF YOU HAVE CONCERNS ABOUT A CHILD'S WELFARE… EVERYONE SHOULD…

- Discuss your concerns and any differences of opinion with your manager, named or designated health professional or designated teacher. If you still have concerns, you or your manager could also, without necessarily identifying the child in question, discuss your concerns with your peers or senior colleagues in other agencies - this may be an important way of you developing an understanding of the reasons for your concerns about the child's welfare.
- If, after this discussion, you still have concerns, and consider the child and their parents would benefit from further services, consider to which agency, including another part of your own, you should make a referral. If you consider the child is or may be a child in need, you should refer the child and family to social services. This may include a child whom you believe is, or may be at risk of, suffering significant harm. Concerns about significant harm may also arise with children who are already known to social services. Information about these children should be given to the allocated social worker within social services. In addition to social services, the police and the NSPCC have powers to intervene in these circumstances.
- In general, seek to discuss your concerns with the child, as appropriate to their age and understanding, and with their parents and seek their agreement to making a referral to social services unless you consider such a discussion would place the child at risk of significant harm (for further guidance on consent see the appendix).
- When you make your referral, agree with the recipient of the referral what the child and parents will be told, by whom and when.

- If you make your referral by telephone, confirm it in writing within 48 hours. Social services should acknowledge your written referral within one working day of receiving it, so if you have not heard back within 3 working days, contact social services again.

SOCIAL WORKERS AND THEIR MANAGERS, IN RESPONDING TO A REFERRAL, SHOULD…

- Following a referral, you and your manager should decide on the next course of action within one working day, and record the decision. Further action may include undertaking an initial assessment, referral to other agencies, provision of advice or information, or no further action.
- If you and your manager decide that you should take no further action at this stage, tell the referrer of this decision and the reasons for making it. Where a referral has been received from a member of the public, do this in a way that is consistent with respecting the confidentiality of each party.
- You and your manager should consider whether a crime may have been committed. If so, involve the police at the earliest opportunity, as it is their responsibility to carry out any criminal investigation in accordance with the agreed plan for the child.
- When you have received a referral from a member of the public, rather than another professional, remember that personal information about referrers, including anything that could identify them, should only be disclosed to third parties (including subject families and other agencies) with the consent of the referrer. If the police are involved, you will need to discuss with them when to inform the parents about referrals from third parties, as this will have a bearing on the conduct of police investigations.

POLICE OFFICERS SHOULD…

- Where you become involved with a child about whom you have child welfare concerns, refer to social services and agree a plan of action.
- Where you are contacted by social services about a child, consider whether to begin a criminal investigation and lead on any investigation.
- Undertake the evidence gathering process whilst working in partnership and sharing relevant information with social services and other agencies.
- Take immediate action where necessary to safeguard a child, consulting with social services and agreeing a plan of action as soon as practicable.

WHAT SHOULD HAPPEN LATER IN THE CHILD PROTECTION PROCESS…

SOCIAL WORKERS AND THEIR MANAGERS SHOULD…

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

POLICE OFFICERS SHOULD…

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

EVERYONE ELSE SHOULD…

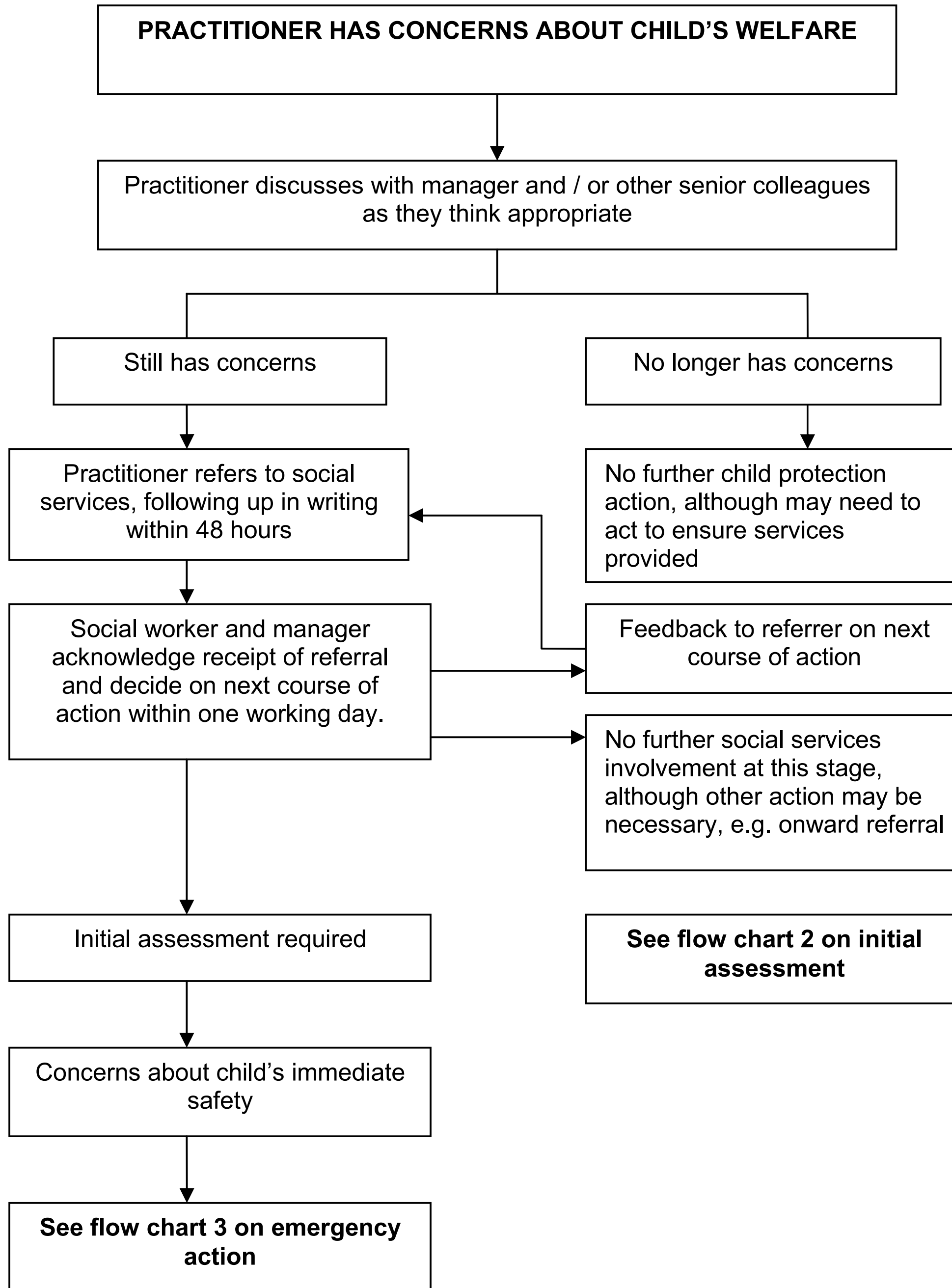
- provide relevant information to social services or the police about the child or family members;
- contribute to initial or core assessments and undertake specialist assessments, if requested, of the child or family members;
- provide support or specific services to the child or member of the family as part of an agreed plan, and contribute to the reviewing of the child's developmental progress.

IF YOU NEED MORE INFORMATION…

Framework for the Assessment of Children in Need and their Families.
Website: www.doh.gov.uk/qualityprotects/work_pro/project_3.htm

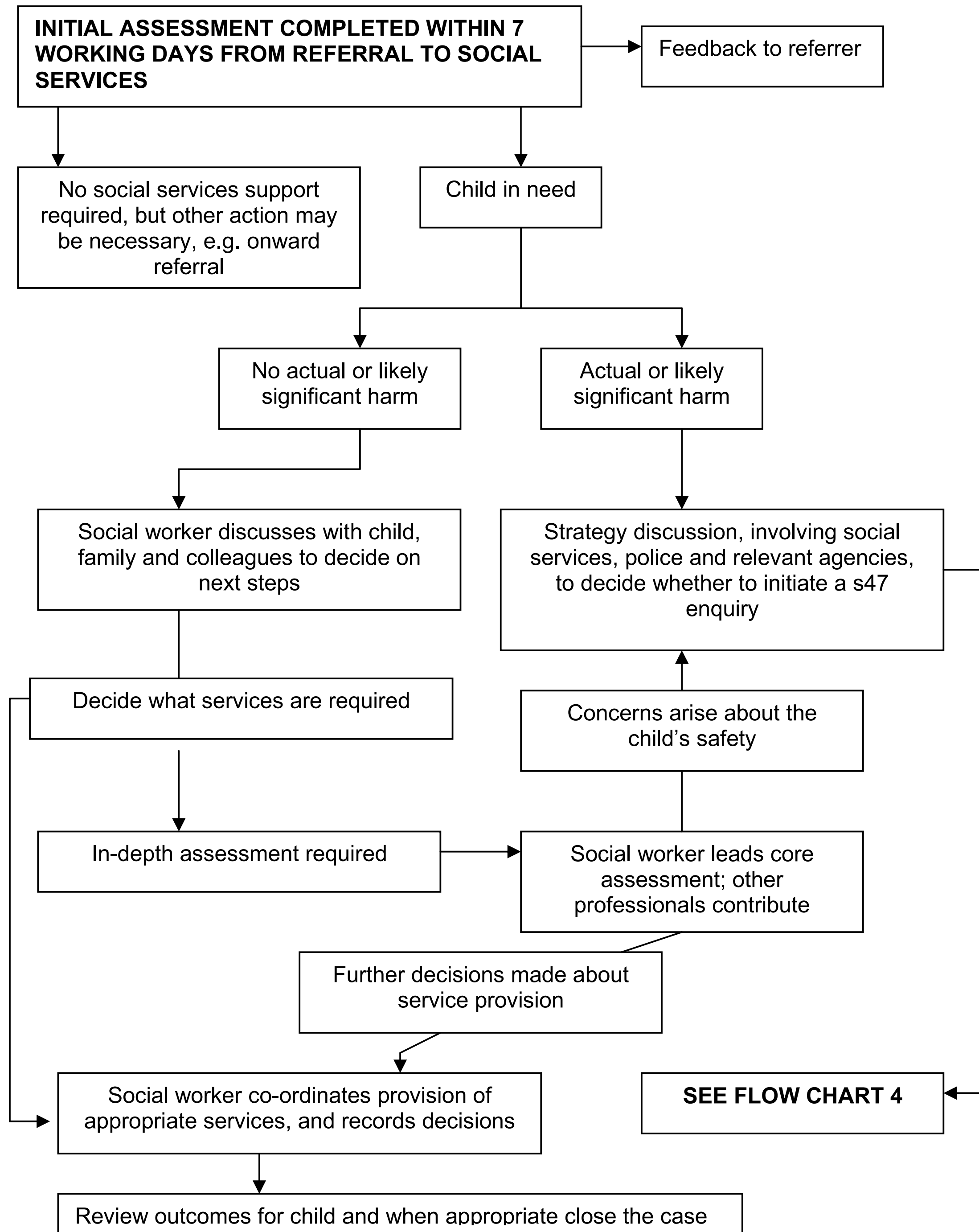
Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.
Website: www.doh.gov.uk/qualityprotects/work_pro/project_3.htm

FLOW CHART 1
REFERRAL

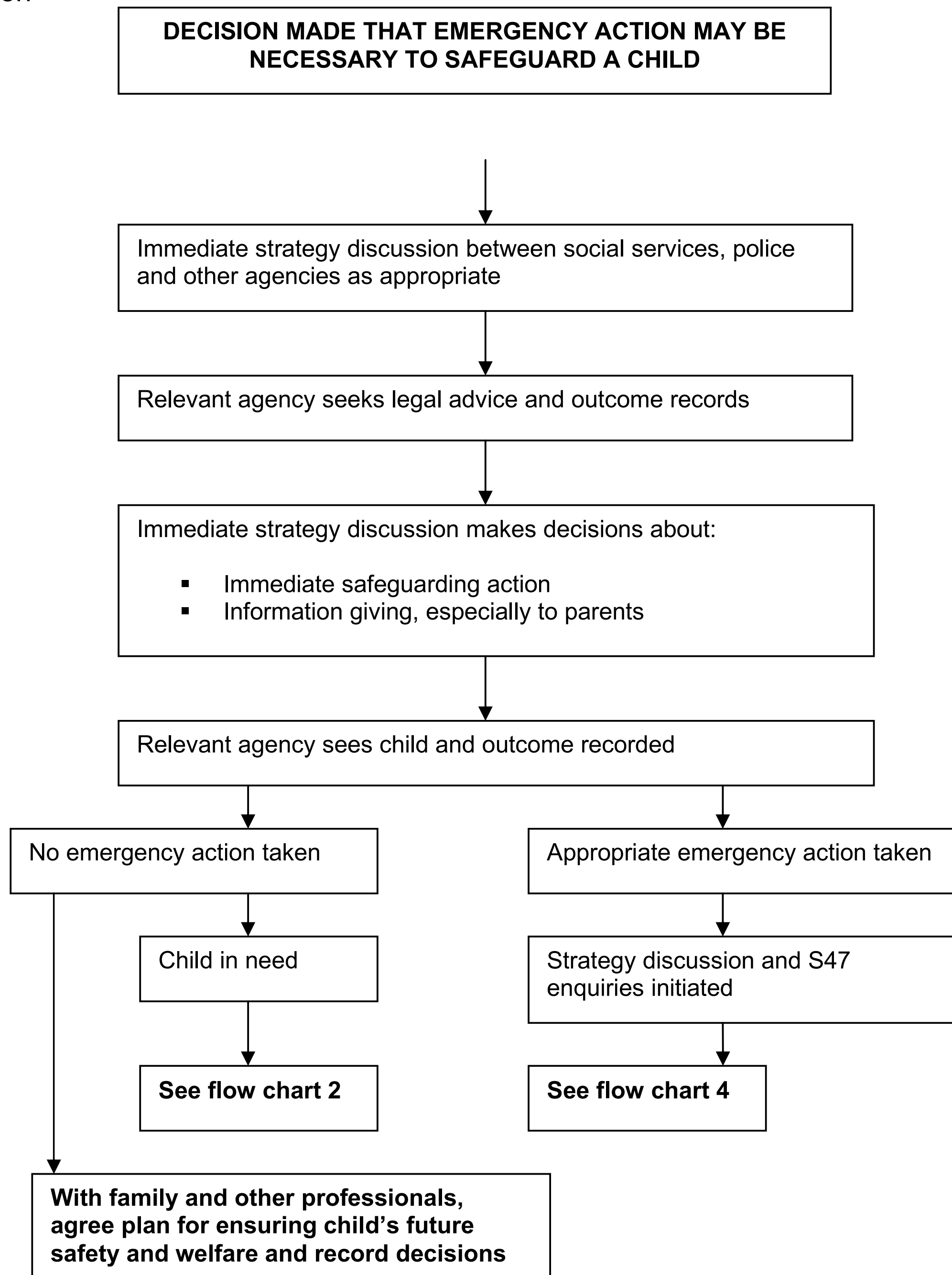


FLOW CHART 2

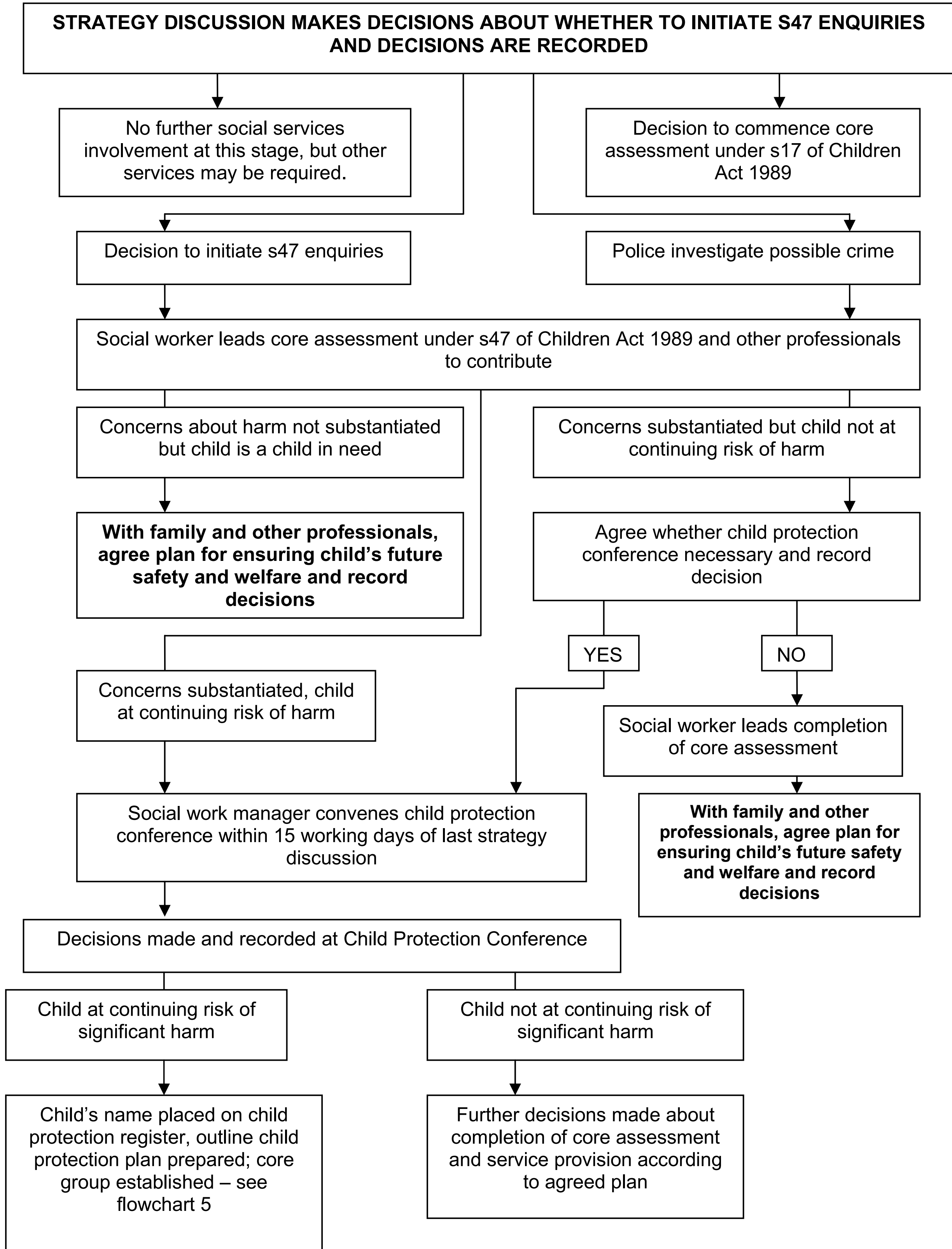
WHAT HAPPENS FOLLOWING INITIAL ASSESSMENT?



FLOW CHART 3 Urgent action to Safeguard Children



FLOW CHART 4
WHAT HAPPENS AFTER THE STRATEGY DISCUSSION?



FLOW CHART 5
What happens after the Child Protection Conference, including the Review Process?