

What To Do If You're Worried A Child Is Being Abused



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Children's Services Guidance

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PREFACE – SAFEGUARDING CHILDREN

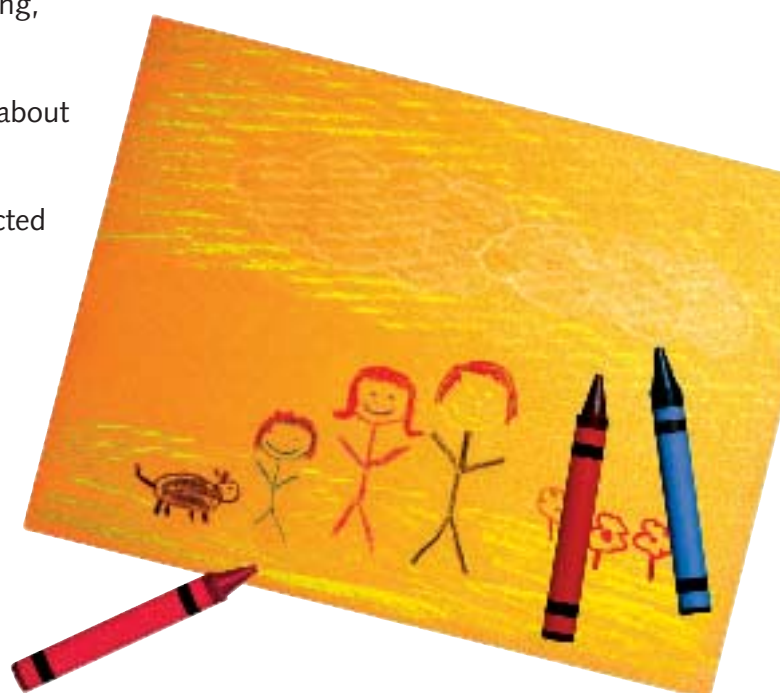
This practice guidance has been developed to assist practitioners to work together to promote children's welfare and safeguard them from harm. It is for anyone whose work brings them into contact with children and families, but particularly those who work in social care, health, education and criminal justice services. It is relevant to those working in the statutory or the independent sector, as well as to members of the wider community, and applies to all children and young people **irrespective of whether they are living at home with their families and carers or away from home**. Where children are living in foster care or in an institutional setting, including custody, assessments and decisions about further action should also include consideration of the role of the responsible carers, residential or custodial staff as well as parents and other family members.

The document recognises that concerns about a child's welfare can vary greatly in terms of the nature and seriousness of those concerns, how those concerns have been identified and over what duration they have arisen. By ensuring that such concerns are appropriately shared with statutory agencies and other individuals responsible for child protection within agencies, the welfare of children and the safeguards provided for them will be enhanced.

The document focuses on:

- what you should do if you have concerns about children, in order to safeguard and promote the welfare of children, including those who are suffering, or at risk of suffering, significant harm;
- what will happen once you have informed someone about those concerns;
- what further contribution you may be asked or expected to make to the processes of assessment, planning, working with children, and reviewing that work, including how you should share information;
- some basic information and background about the legislative framework within which children's welfare is safeguarded and promoted (Appendix 2).

Appendix 3 is designed to assist you when making decisions about consent, confidentiality and information sharing. References to the relevant Government Guidance on safeguarding and promoting the welfare of children are to be found on page 50.





This publication is issued jointly by the Department of Health, the Home Office, the Department for Education and Skills, the Department for Culture, Media and Sport, the Office of the Deputy Prime Minister and the Lord Chancellor's Department.

It summarises briefly the key processes but does not replace *Working Together to Safeguard Children (1999)* or the *Framework for the Assessment of Children in Need and their Families (2000)*.

This document does, however, replace *Child Protection – Medical Responsibilities – Guidance to Doctors working with Child Protection agencies: Addendum to Working Together under the Children Act 1989 and Child Protection: Guidance for senior nurses, health visitors, midwives and their managers* and *Appendix 5* entitled Individual cases flow chart in *Working Together to Safeguard Children* (p.116).

INTRODUCTION – WORKING WITH CHILDREN ABOUT WHOM THERE ARE CHILD WELFARE CONCERNS

1 Achieving good outcomes for children requires all those with responsibility for assessment and the provision of services to work together according to an agreed plan of action. Effective collaborative working requires professionals and agencies to be clear about:

- their roles and responsibilities for safeguarding and promoting the welfare of children;
- the purpose of their activity, what decisions are required at each stage of the process and what are the intended outcomes for the child and their family members;
- the legislative basis for the work;
- the protocols and procedures to be followed, including the way in which information will be shared across professional boundaries and within agencies, and be recorded;
- which agency, team or professional has lead responsibility, and the precise roles of everyone else who is involved, including the way in which the children and other family members will be involved;
- any timescales set down in Regulations or Guidance which govern the completion of assessments, making of plans and timing of reviews.

WHAT IS A CHILD IN NEED?

2 Children who are defined as being 'in need', under the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their

health and development will be significantly impaired, without the provision of services (s17(10) of the Children Act 1989). The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are what will happen to a child's health or development **without services**, and the likely effect the services will have on the child's standard of health and development.

WHAT IS SIGNIFICANT HARM?

3 Some children are in need because they are suffering or likely to suffer significant harm. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. The local authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm (s47 of the Children Act 1989). To make enquiries involves assessing what is happening to a child. Where s47 enquiries are being made, the assessment (known as the 'core assessment') should concentrate on the harm that has occurred or is likely to occur to the child as a result of child maltreatment, in order to inform future plans and the nature of services required. Decisions about significant harm are complex and should be informed by a careful assessment of the child's circumstances, and discussion between the statutory agencies and with the child and family.

WHAT IS ABUSE AND NEGLECT?

4 A person may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children and young people may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.

- **Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately causing, ill health to a child.
- **Emotional abuse** is the persistent emotional ill-treatment 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, age or developmentally inappropriate expectations being imposed on children, causing children frequently to feel frightened, or the exploitation or corruption of children.
- **Sexual abuse** involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include involving children in looking at, or in the production of, pornographic material, or encouraging children to behave in sexually inappropriate ways.

- **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, such as failing to provide adequate food, shelter and clothing, or neglect of, or unresponsiveness to, a child's basic emotional needs.

THE PROCESSES FOR SAFEGUARDING CHILDREN

5 Four key processes underpin work with children in need and their families, each of which needs to be carried out effectively in order to achieve improvements in the lives of children in need. They are assessment, planning, intervention and reviewing (Department of Health, 2002a). At any stage, a referral may be necessary from one agency to another, or received from a member of the public.

6 The flow charts in this document (pp10–14) illustrate the processes for safeguarding and promoting the welfare of children:

- from the point that concerns are raised about a child and are referred to a statutory 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).

CHILD WELFARE CONCERNS...

7 Child welfare concerns may arise in many different contexts, including where a child or family is already known to social services. There may be a number of explanations for the perceived impairment to a child's health or development and each requires careful consideration and review.

IN GENERAL...

8 All those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to 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. This may happen regardless of who made the referral to social services;
- you may be asked to provide help or a specific service to the child or a member of their family as part of an agreed plan and contribute to the reviewing of the child's progress.



9 Some who may also come into the above category, such as paediatricians, speech therapists and psychologists, may be asked to undertake specific types of assessments as part of an initial or core assessment, to provide reports to inform a child protection conference, to attend that conference, or to contribute to ongoing therapeutic work with a child and a review of that work.

ALL PRACTITIONERS WORKING WITH CHILDREN AND FAMILIES SHOULD...

10.1 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.

10.2 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.

10.3 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.

10.4 Refer any concerns about child abuse or neglect to social services or the police.

10.5 Have an understanding of the *Framework for the Assessment of Children in Need and their Families* (see Figure 1), which underpins the processes of assessing needs, planning services and reviewing the effectiveness of service provision at all stages of work with children and families. (The dimensions of the Connexions Service APIR Framework are based on those in the Assessment Framework.)

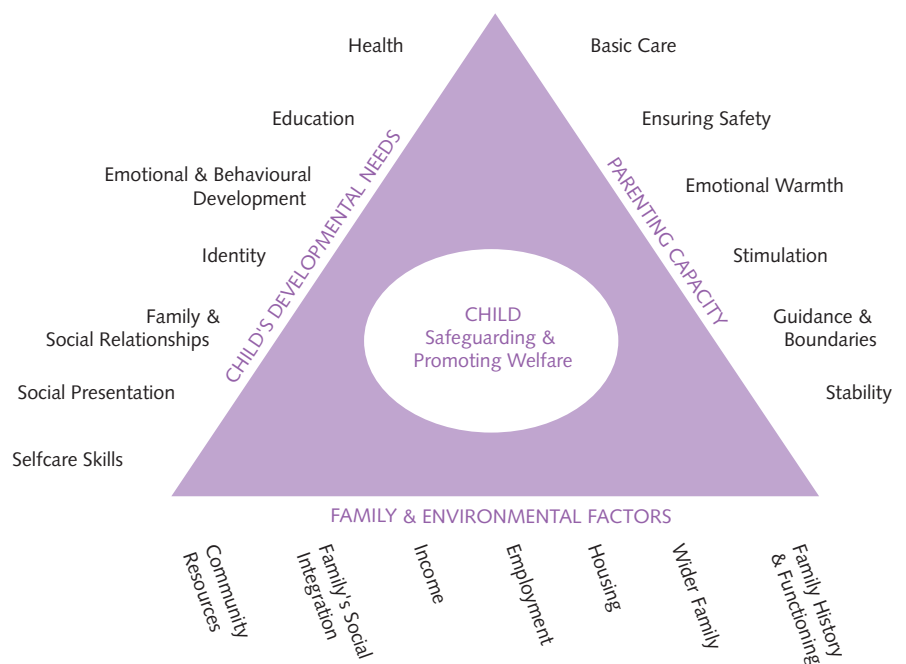
10.6 When referring a child to social services you should consider and include any information you have on the child's developmental needs and their parents'/carers' ability to respond to these needs within the context of



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 respect of each of these three domains. Specialist assessments, in particular, are likely to provide information in a specific dimension, such as health, education or family functioning.

10.7 See the child as part of considering what action to take in relation to concerns about the child's welfare.

FIGURE 1 Assessment Framework



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

10.9 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.

10.10 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.

10.11 Talk to your manager and other professionals: always share your concerns, and discuss any differences of opinion. Follow up your concerns. Always follow up oral communications to other professionals in writing and ensure your message is clear.

IF YOU HAVE CONCERNS ABOUT A CHILD'S WELFARE...

ALL PRACTITIONERS SHOULD...

11.1 Discuss your concerns 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.

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

11.3 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 (Appendix 3 provides further guidance on consent).

11.4 When you make your referral, agree with the recipient of the referral what the child and parents will be told, by whom and when.

11.5 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...

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

12.2 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 confidentiality of each party.

12.3 Consider new information about a child or family with whom you are already in contact. If this information causes you to be concerned about a child's safety then discuss it with your manager. If you consider the child is or may be suffering harm, decide whether, as the child and family will be well known to social services, it is appropriate to hold a strategy discussion without undertaking an initial assessment.

12.4 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.

12.5 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...

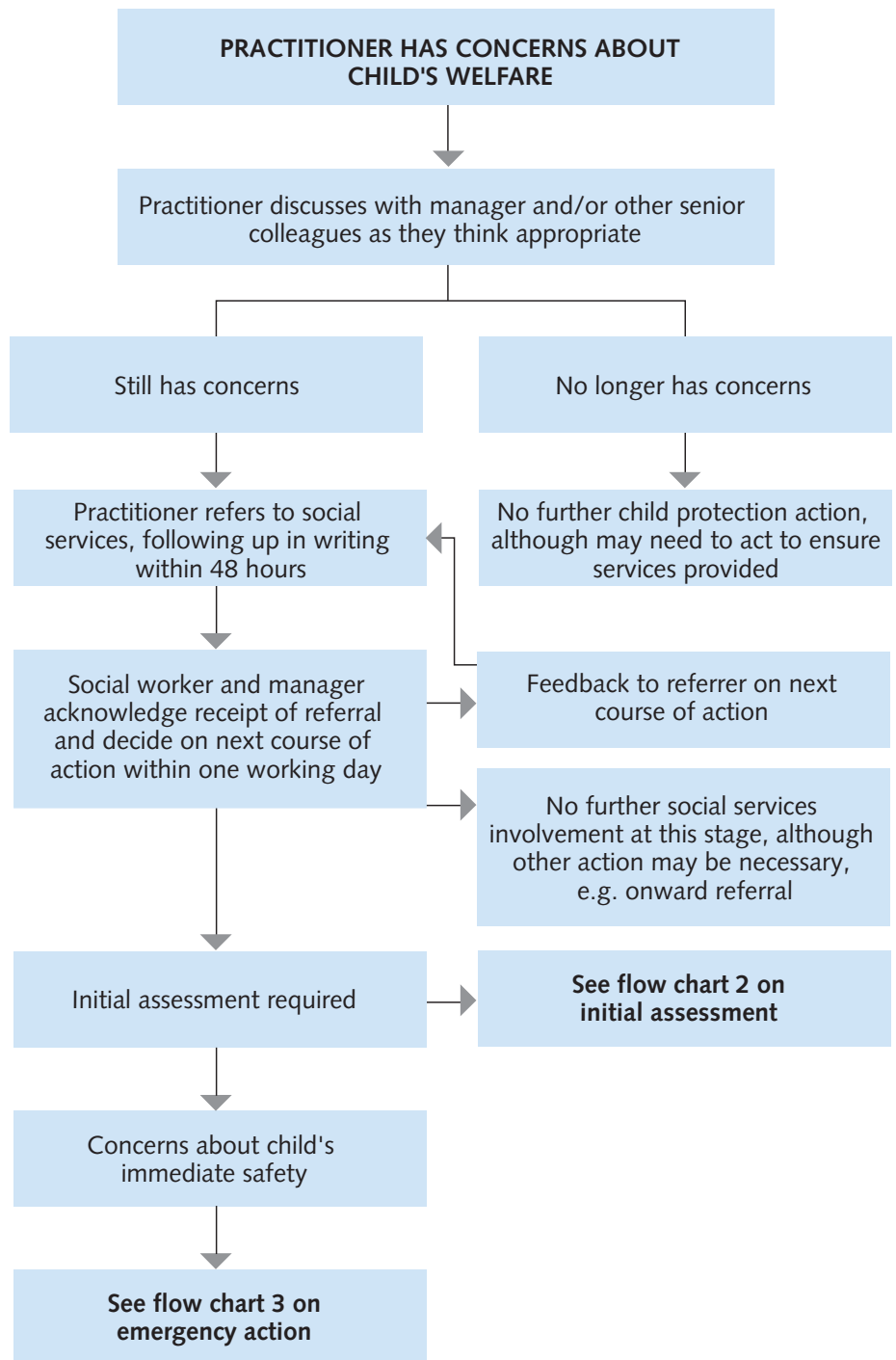
13.1 Where you become involved with a child about whom you have child welfare concerns, refer to social services and agree a plan of action.

13.2 Where you are contacted by social services about a child, consider whether to begin a criminal investigation and lead on any investigation.

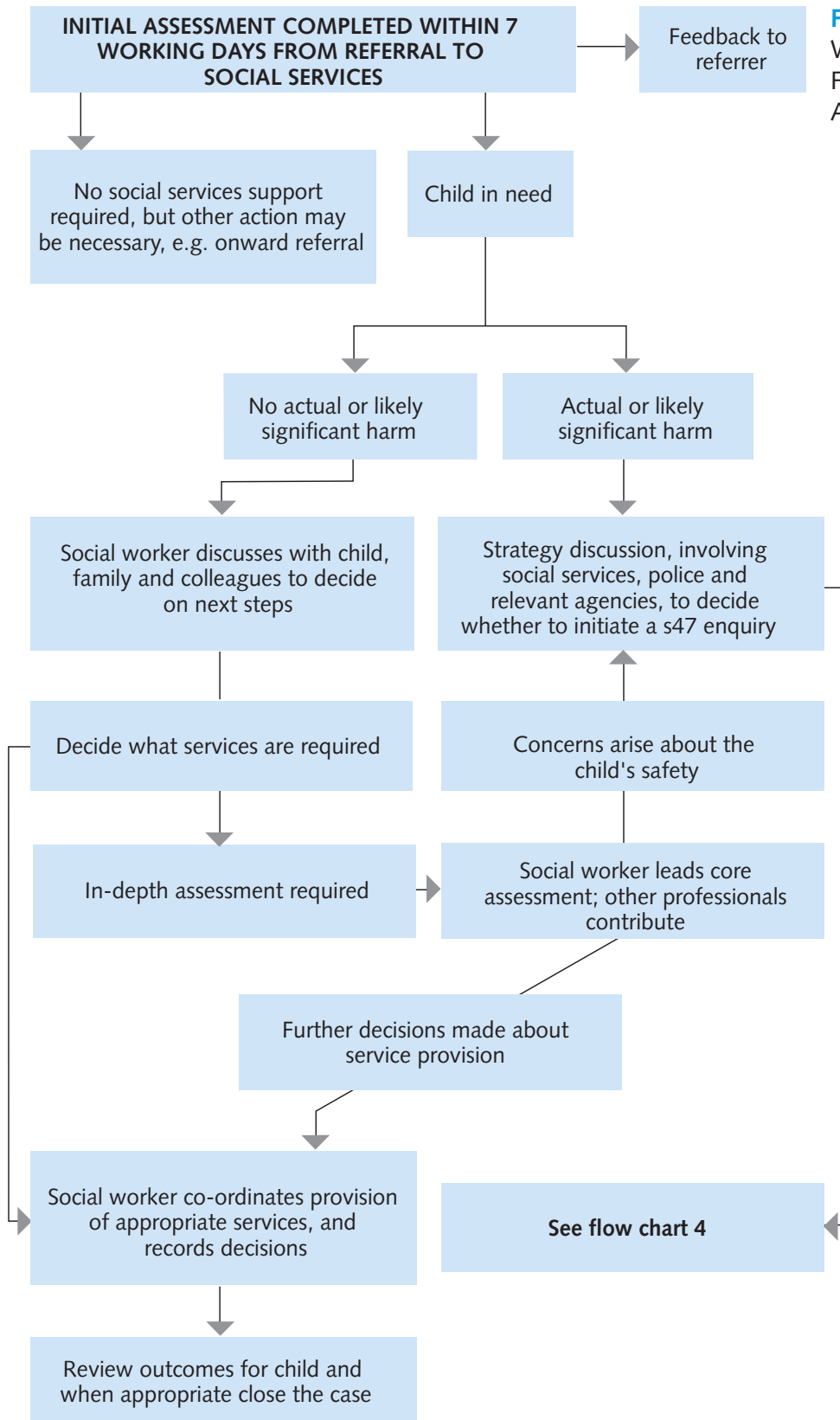
13.3 Undertake the evidence gathering process whilst working in partnership and sharing relevant information with social services and other agencies.

13.4 Take immediate action where necessary to safeguard a child, consulting with social services and agreeing a plan of action as soon as practicable.

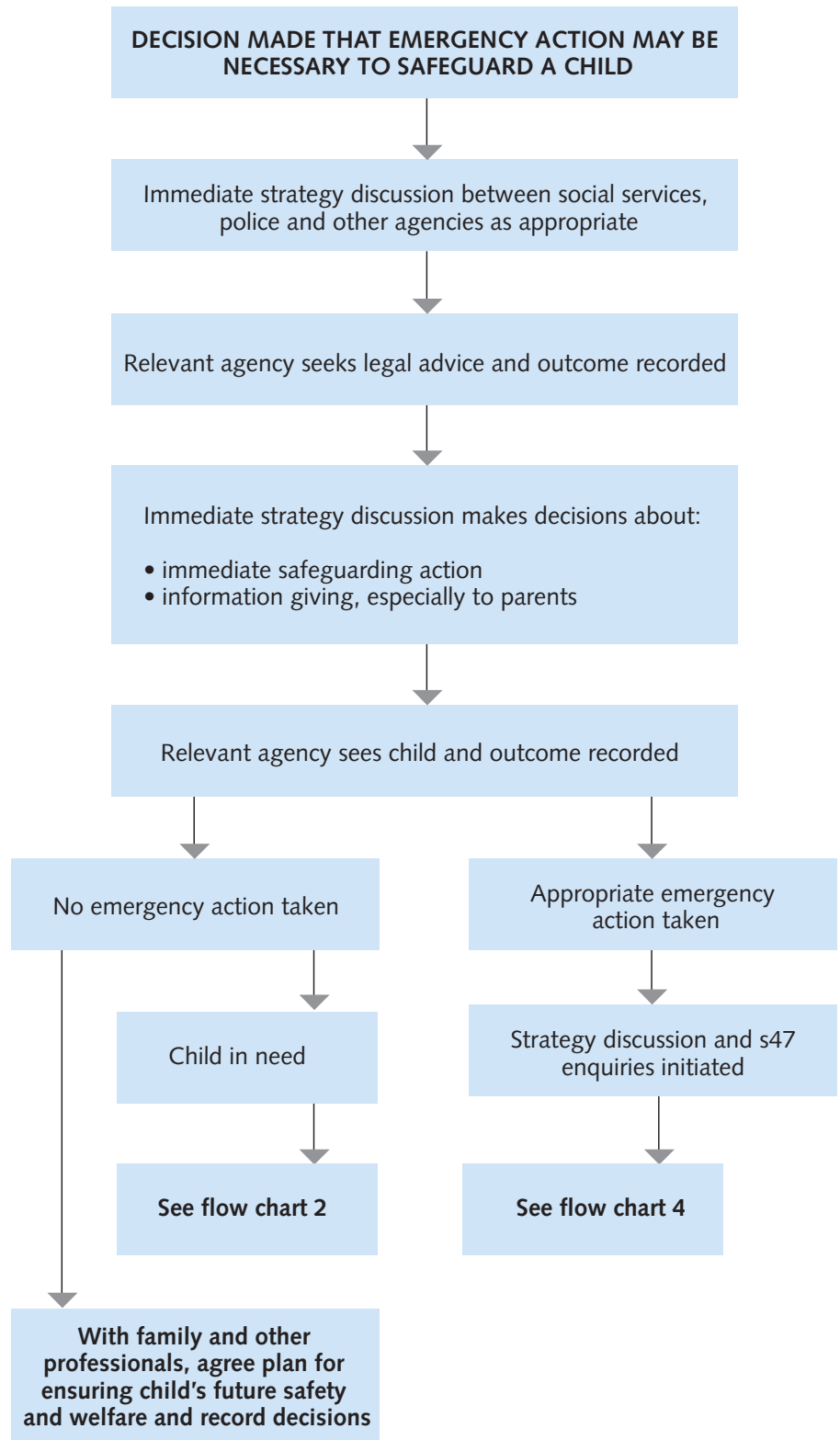
FLOW CHART 1
REFERRAL



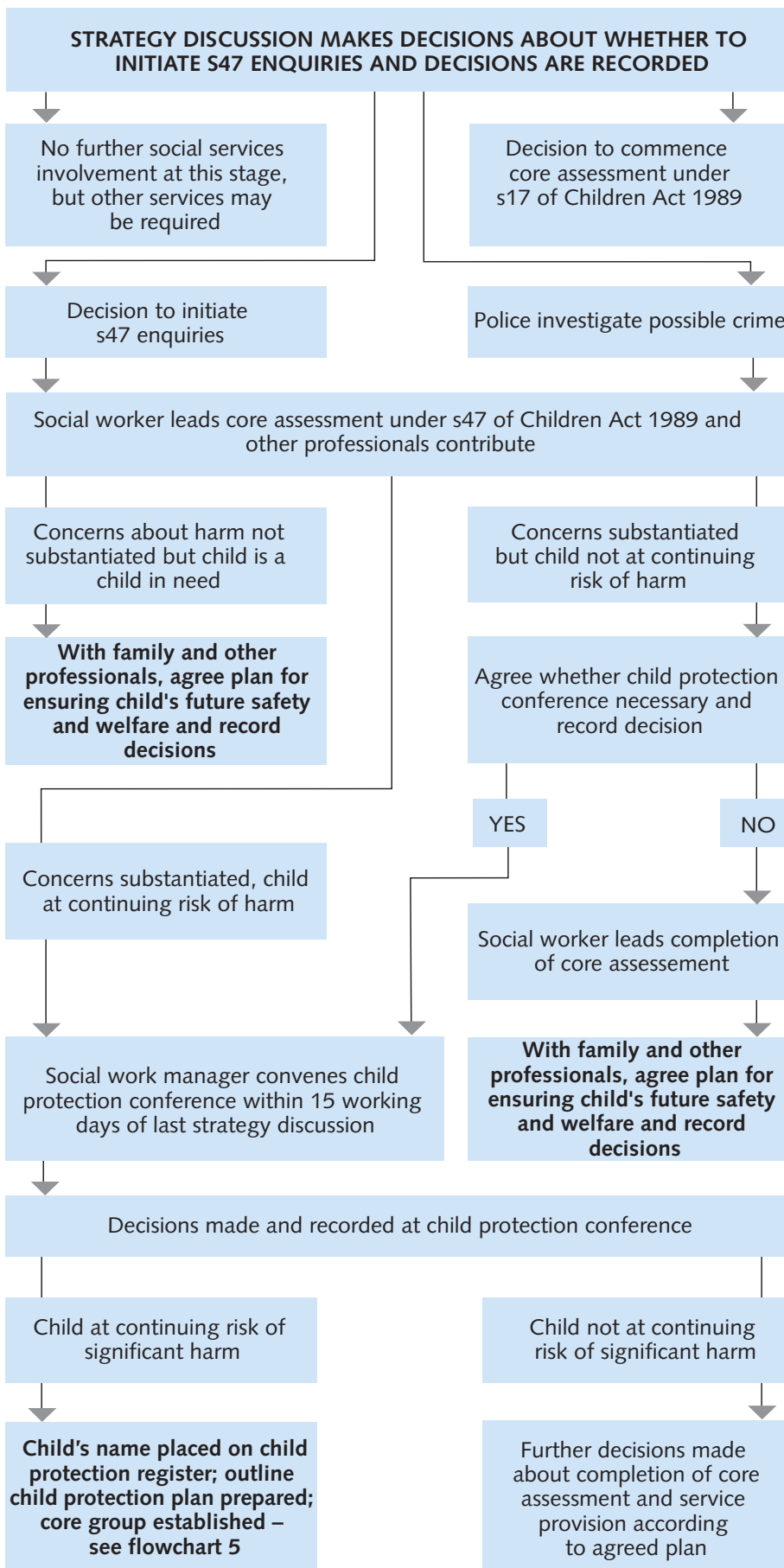
FLOW CHART 2
WHAT HAPPENS
FOLLOWING INITIAL
ASSESSMENT?



FLOW CHART 3
URGENT ACTION TO
SAFEGUARD CHILDREN

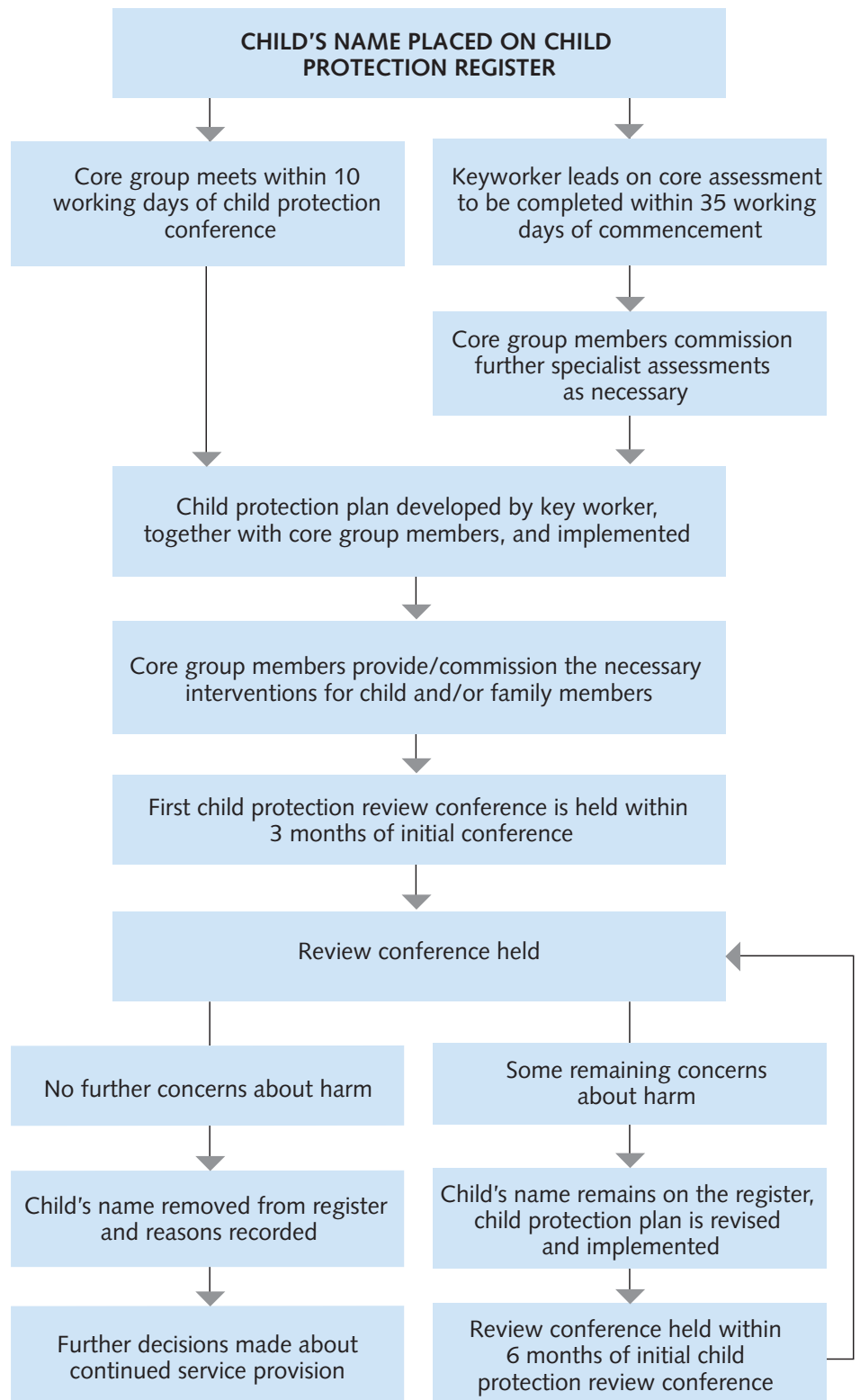


FLOW CHART 4
WHAT HAPPENS AFTER THE STRATEGY DISCUSSION?



FLOW CHART 5

WHAT HAPPENS AFTER THE CHILD PROTECTION CONFERENCE, INCLUDING THE REVIEW PROCESS?



IF AN INITIAL ASSESSMENT IS REQUIRED...



14 An initial assessment is a brief assessment of each child referred to social services to determine “whether the child is in need, the nature of any services required, and whether a further, more detailed core assessment should be undertaken” (paragraph 3.9 of the Assessment Framework). The initial assessment should be undertaken in accordance with the Assessment Framework. Information should be gathered and analysed within the three domains of the Assessment Framework (see Figure 1), namely:

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

15 The initial assessment should be carefully planned, with clarity about who is doing what, as well as when and what information is to be shared with the parents. The planning process and decisions about the timing of the different assessment activities should be undertaken in collaboration with all those involved with the child and family.

SOCIAL WORKERS SHOULD...

16.1 Lead on an initial assessment and complete it within 7 working days, in accordance with *The Framework for the Assessment of Children in Need and their Families*.

16.2 See the child within a timescale that is appropriate to the nature of the concerns expressed at referral, according to an agreed plan (which may include seeing the child without his or her carers present). This includes observing and communicating with the child in a manner appropriate to his or her age and understanding. The child’s views should be ascertained and understood.

16.3 Conduct interviews with child and family members, separately and together as appropriate. These should be undertaken in the preferred language of the child and each family member. For some disabled children and family members expertise in non-verbal communication will be necessary. **It will not necessarily be clear whether a criminal offence has been committed**, so even initial discussions with the child should be conducted in a way that minimises distress to them and maximises the likelihood that they will provide accurate and complete information, avoiding leading or suggestive questions.

16.4 Involve relevant agencies who are working with/or known to the child and family in gathering and providing information, as appropriate (for further information on information sharing, see Appendix 3).



16.5 Once the initial assessment is complete, together with your manager and all other relevant agencies, decide on further action. Involve the child and parents in these discussions, unless this may place a child at risk of significant harm again, for example, the child may be physically abused for talking about his/her abuse. If you have concerns about a parent's ability to protect their child, consider carefully what the parents should be told when and by whom, taking account of the child's welfare.

16.6 Record the assessment findings and your initial analysis and decisions following the initial assessment, including the reasons for any decisions made and further action to be taken in the Initial Assessment Record (Department of Health, 2002c). Inform, in writing, all the relevant agencies and the family of your decisions and, if the child is a child in need, of the plan for providing support to them and their child.

POLICE OFFICERS SHOULD...

17.1 Consider how you might be able to assist other agencies carry out their responsibilities and, where there are child protection concerns, whether or not a crime has been committed.

ALL PRACTITIONERS SHOULD...

18.1 Be involved in the initial assessment process according to the agreed plan, including providing further information about the child and family, and in the process of agreeing further action.

18.2 Seek information from relevant services if the child and family have spent time abroad. Professionals from such agencies as health, social services or the police should request this information from their equivalent agencies in the country(ies) in which the child has lived. Information about who to contact can be obtained via the Foreign and Commonwealth Office on 020 7008 1500 or the appropriate Embassy or Consulate based in London (you can obtain contact information about all the Embassies in London – the London Diplomatic List, ISBN 0 11 591772 1 – from the Stationery Office on 0870 600 5522 or from the FCO website www.fco.gov.uk)

WHAT HAPPENS NEXT WHEN THERE IS... ...NO SUSPECTED ACTUAL OR LIKELY SIGNIFICANT HARM?

SOCIAL WORKERS SHOULD...

19.1 Decide with your manager whether you think the child may be a child in need and if so whether it would be appropriate to undertake a core assessment in order to determine what help may benefit the child and family or alternatively whether to offer services to the child or family based on the findings of the initial assessment.

19.2 Discuss any options for further action with the child and parents in the light of the findings of the initial assessment and consideration of what would be most helpful to the child and family.

19.3 Discuss the findings of the initial assessment with other relevant professionals to inform decisions about what types of services, including a core assessment, it would be appropriate to offer.

...SUSPECTED ACTUAL OR LIKELY SIGNIFICANT HARM?

SOCIAL WORKERS SHOULD...

20.1 Initiate a strategy discussion to enable you and your managers together with other agencies to decide whether to initiate enquiries under s47 of the Children Act 1989 and therefore to commence a core assessment as the means by which these enquiries will be undertaken.

20.2 Consider carefully what parents are told, when and by whom. The police, GP, health visitor, school nurse, any paediatrician who knows the child, the senior ward nurse (if the child is an in-patient), teacher and other relevant professionals should be involved in making these decisions.

20.3 If the child is physically present in your Council's area, regardless of where he or she actually lives, you need to initiate a strategy discussion to decide whether there is evidence to support commencing s47 enquiries, or to apply for an emergency protection order unless appropriate alternative arrangements have been made with the Council where the child normally lives.

20.4 If the child is normally resident in another Council, you or your manager should negotiate a transfer of statutory responsibility to the child's Council of residence and agree how the child's case will be managed before relinquishing lead responsibility. In these circumstances who takes lead responsibility will depend on a number of factors, such as where the child is going to continue to be living in the near future and whether the allegations relate to a person living or working in the same area as the child is living currently or not.

20.5 If you think that a criminal offence may have been committed against a child, you should involve the police as soon as possible. You and the police will then consider together with other relevant agencies how to proceed to safeguard the child.

POLICE OFFICERS SHOULD...

21.1 Respond to information from social services and decide what further action it might be necessary to take, including taking full responsibility for carrying out any criminal investigation in a prompt and efficient manner.

IF YOU NEED TO TAKE URGENT ACTION TO PROTECT A CHILD...

22 Where there is a risk to the life of a child or a likelihood of serious immediate harm, an agency with statutory child protection powers, i.e. social services, police or NSPCC, **should act quickly to secure the immediate safety of the child** (see paragraph 8 in Appendix 2 for a summary of statutory orders to protect a child).

SOCIAL WORKERS, POLICE OFFICERS OR NSPCC WORKERS SHOULD...

23.1 Initiate a strategy discussion immediately to discuss planned emergency action or as soon as possible after an agency has had to take immediate protective action.

23.2 See the child (this should be done by a practitioner from the agency taking the emergency action) as part of deciding how best to protect him or her, including deciding whether to seek an emergency order.

23.3 Normally obtain legal advice before initiating legal action, in particular when an Emergency Protection Order is being sought. **Police protection powers should only be used in exceptional circumstances where there is insufficient time to seek an Emergency Protection Order or for reasons relating to the immediate safety of the child.**

23.4 When considering whether emergency action is necessary, always consider whether action is required to safeguard other children in the same household (e.g. siblings), in the household of an alleged perpetrator, or elsewhere. The nature of the abuse will be a key determining factor, i.e. if it is known a child's life is in danger then **immediate action ought to be taken.**

23.5 Record the decisions made at the Strategy Discussion (Department of Health, 2002c). Keep under constant review decisions about possible immediate action.

IF YOU NEED TO HAVE A STRATEGY DISCUSSION...

24 If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, social services should convene a strategy discussion. Depending on the nature of the child's needs and the urgency of the situation, this might take the form of an actual meeting, or be a series of telephone conversations. In complex types of maltreatment or neglect a meeting **is likely to be** the most effective way of discussing the child's welfare and planning future action. More than one strategy discussion may be necessary. This is likely to be where the child's circumstances are very complex and a number of discussions are required

to consider whether and, if so, when to initiate s47 enquiries. Such a meeting should be held at a convenient location for the key attendees, such as a hospital, school, police station or social services office.

25 The purpose of the strategy discussion is to agree whether to initiate s47 enquiries and as a consequence to commence or, where one is already in progress, to complete a core assessment under this section of the Children Act 1989. It is also to identify the relevant tasks and timescales for each involved professional and agency, and agree what further help or support may be necessary.

WHAT ARE THE TASKS OF THE STRATEGY DISCUSSION?

26 The discussion should be used to undertake the following tasks:

- share available information;
- agree the conduct and timing of any criminal investigation;
- decide whether a core assessment under s47 of the Children Act (s47 enquiries) should be initiated or continued if it has already begun;
- where it is decided that there are grounds to initiate a s47 enquiry decisions should be made about:
 - how the core assessment under s47 will be carried out – what further information is required about the child and family and how it should be obtained and recorded;
 - who will carry out what actions, by when and for what purpose;
- agree what action is required immediately and in the short term to safeguard the child, and/or provide interim services and support. This will include, where a child is in hospital, how to secure the safe discharge of the child;
- determine what information about the strategy discussion will be shared with the family, unless such information sharing may place a child at risk of significant harm or jeopardise police investigations into any alleged offence(s); and
- determine if legal action is required.

WHO SHOULD BE INVOLVED IN THE STRATEGY DISCUSSION?

27 The following professionals may be involved in a strategy discussion:

- The staff involved should be sufficiently senior to be able to contribute to the discussion of information, and to make decisions on behalf of their agencies. The agencies represented should include





at a minimum social services, the police and relevant others, including the referring agency, the child's nursery/school and health;

- If the child is a hospital patient (in- or out-patient) or receiving services from a child development team, the strategy discussion should involve the medical consultant responsible for the child's health care and, if the child is an in-patient, a senior ward nurse;
- Where a medical examination may be necessary or has already taken place a senior doctor from the providing service should be included;
- It may also be appropriate to involve the local authority's solicitor;
- It is important also to consider whether it is necessary to seek advice from, or have present, additional professionals who have expertise in the particular type of suspected maltreatment or neglect. This would enable complex information to be presented and evaluated from a sound evidence base.

A TEAM MANAGER OR SENIOR SOCIAL WORKER SHOULD...

28.1 Ensure that the strategy discussion takes place and that it considers the child's welfare and plans future actions.

28.2 Ensure that the discussion identifies what information will be shared with the family and child, on the basis that the information is not shared if to do so may place a child at risk of significant harm or jeopardise police investigations.

28.3 Record the agreed decisions and actions on the Strategy Discussion Record (Department of Health, 2002c) and send this record to all relevant professionals and agencies.

28.4 Consider what further action is required where an Emergency Protection Order is in place or the child is the subject of police powers of protection.

POLICE OFFICERS SHOULD...

29.1 Discuss the basis for any criminal investigation, and any relevant processes that other agencies might need to know about, including the timing and methods of evidence gathering.

HEALTH PROFESSIONALS SHOULD...

30.1 Where the child is in hospital, consider how best to ensure safe transfer of the child, when she or he is fit for discharge in discussion and agreement with other core agencies.

ALL PROFESSIONALS SHOULD...

31.1 Provide available information verified at source, in a clear and comprehensible format.

WHAT HAPPENS WHEN S47 ENQUIRIES ARE INITIATED?

32 A core assessment is the means by which a s47 enquiry is carried out. It is an in-depth assessment that addresses the central or most important aspects of the needs of a child and the capacity of his or her parents or caregivers to respond appropriately to these needs within the wider family and community context. The core assessment should begin by focusing primarily on the information identified during the initial assessment as being of most importance when considering whether the child is suffering or is likely to suffer significant harm. It should, however, cover all relevant dimensions in the Assessment Framework before its completion.

SOCIAL WORKERS SHOULD...

33.1 Lead on the core assessment as set out in the *Framework for the Assessment of Children in Need and their Families* and record the findings in the Core Assessment Record (Department of Health, 2002c).

33.2 In particular, see the child and communicate with him or her to assess their understanding, if old enough, of their situation and the nature of their relationship with each significant family member (including all caregivers).

33.3 Determine each of the caregivers' relationships with the child, the parents' relationship with each other and the children in the family, as well as the wider family, social and environmental factors impacting on them. Use relevant Questionnaires and Scales (see Appendix 1 for details) to obtain information on specific areas of family life.

33.4 Systematically gather information about the history of the child and each family member, building on that already gathered during the course of each agency's involvement with the child and record it in the chronology. Use the findings from any specific assessments of the child and/or family members to inform the core assessment.

33.5 Keep careful and detailed notes, as this is very important for any subsequent police investigation or court action. Record any unusual events and make a distinction between events reported by the carer and those actually witnessed by others including professionals. Notes should be timed, dated and signed legibly and kept in a secure place so that they are not able to be accessed by unauthorised persons.

33.6 At the conclusion of this phase of the assessment, together with your manager and other professionals, analyse the findings to reach an understanding of the child's circumstances which should inform future plans, case objectives and decisions about what types of services should be provided.

POLICE OFFICERS SHOULD...

34.1 Assist staff from other agencies to understand the reasons for the concerns about the child's welfare including their safety. While your investigations may produce conclusive evidence of maltreatment, they may also confirm that the carer is not responsible for causing the child harm.

34.2 Whether or not police investigations reveal grounds for instigating criminal proceedings, make available to other professionals any evidence that you have gathered, to inform discussions about the child's welfare.

34.3 Where you obtain evidence that a criminal offence has been committed by the parent or carer, and a prosecution is contemplated, it is important that the suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984. This would normally rule out, for example, the suspect being confronted with the evidence by personnel from the statutory agencies, other than the police as the lead investigative agency.

34.4 Where a decision had been made to undertake an interview of the child as part of the criminal investigations, you and your colleagues from other agencies should follow the guidance set out in *Achieving Best Evidence in Criminal Proceedings: Guidance for vulnerable or intimidated witnesses, including children*.

HEALTH PRACTITIONERS SHOULD...

35.1 Undertake further medical tests, examinations or observations depending on the evidence available about how the child's health or development may be being impaired.

35.2 The lead health practitioner (probably a consultant paediatrician, or possibly the child's GP) may also need to commission any of a range of specialist assessments. For example, physiotherapists, occupational therapists, speech therapists and child psychologists may be involved in specific assessments relating to the child's developmental progress.

35.3 Ensure appropriate follow-up of health concerns.

ALL OTHER PRACTITIONERS SHOULD...

36.1 Contribute to the core assessment and the analysis of the findings as required and requested by social services, including providing information you hold about the child or parents, contribute specialist knowledge or advice to social services or undertake specialist assessments.

36.2 Keep careful and detailed contemporary notes, as this is very important for any subsequent police investigation or court action. You should record any unusual events and make a distinction between events reported by the carer and those actually witnessed by others including professionals. Notes should be timed, dated and signed

legibly and kept in a secure place so that they are not able to be accessed by unauthorised persons.

WHAT HAPPENS IF AFTER THE S47 ENQUIRIES... CONCERNS ARE NOT SUBSTANTIATED?

SOCIAL WORKERS SHOULD...

37.1 Discuss with the parents and other professionals, drawing on an understanding from the assessment and/or police investigations, what further help or support the family may require, for example, with parenting difficulties. This may be related to the child's health or development or to more general matters within the family.

37.2 Consider whether the child's health and development require continued monitoring against specific objectives and who has responsibility for this monitoring.

37.3 Consider whether further work is required to complete the core assessment in order to decide what further help or support the family may require, and if so, complete it.

37.4 Record all decisions and the reasons for them on the Outcome of the s47 Enquiries Record (Department of Health, 2002c).

OTHER PROFESSIONALS SHOULD...

38.1 Participate in these discussions and considerations when requested.

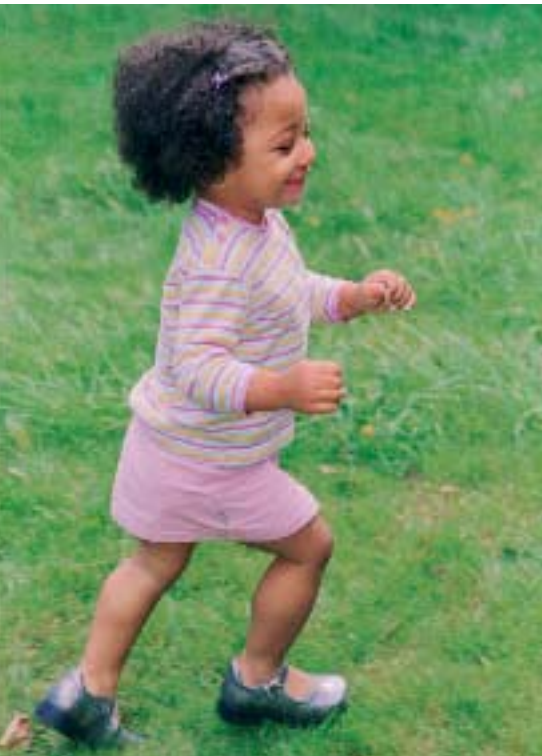
38.2 Contribute to the completion of the core assessment as appropriate.

38.3 Provide services as specified in the plan for the child.



...CONCERNS ARE SUBSTANTIATED, BUT THE CHILD IS NOT JUDGED TO BE AT CONTINUING RISK OF SIGNIFICANT HARM?

39 There may be substantiated concerns that a child has suffered significant harm, but it is agreed between the agencies involved with the child and family that a plan for ensuring the child's future safety and welfare can be developed and implemented without the need for a child protection conference or a child protection plan. Such an approach will be of particular relevance where it is clear to the agencies involved that there is no continuing risk of significant harm. This is particularly relevant where, for example, the carer has taken responsibility for the harm they caused the child, the family's circumstances have changed or the person responsible for the harm is no longer in contact with the child.



SOCIAL WORKERS SHOULD...

40.1 Discuss the findings of the s47 enquiry and agree with the other agencies involved with the child and family that a plan for ensuring the child's future safety and welfare can be developed and implemented without the need for a child protection conference or a child protection plan.

40.2 Record all decisions and reasons for them on the Outcome of the s47 Enquiries Record (Department of Health, 2002c).

40.3 If necessary, complete the core assessment, to inform the development of the child's plan. In particular, the child's health and development may require careful monitoring over time with milestones for progress clearly set out in the plan.

40.4 Explain to the child, as appropriate, and the parents, the nature and purpose of this monitoring by agencies other than social services, and clarify who has responsibility for which parts of the monitoring.

SOCIAL SERVICES MANAGERS SHOULD...

41.1 Consider carefully, together with social workers and other agencies, whether to proceed to a child protection conference where it is known that a child has suffered significant harm.

41.2 Convene a child protection conference where all agencies agree this is appropriate, or where one or more other professionals, supported by a senior manager or a named or designated professional, requests one.

POLICE OFFICERS SHOULD...

42.1 Consider whether or not to continue with a criminal investigation.

OTHER PROFESSIONALS SHOULD...

43.1 Be fully involved in decisions and any future plan for the child and family.

43.2 Be fully involved in discussions about whether to convene a child protection conference.

43.3 Request that social services convene a child protection conference if you have serious concerns that a child may not otherwise be adequately safeguarded.

... CONCERNS ARE SUBSTANTIATED AND THE CHILD IS JUDGED TO BE AT CONTINUING RISK OF SIGNIFICANT HARM?

SOCIAL SERVICES MANAGERS SHOULD...

44.1 Ensure that a child protection conference is convened, within 15 working days of the strategy discussion (or the last, if more than one has been held) to enable those professionals most involved with the child and family, and the child and family themselves, to assess all relevant information and plan how to safeguard the child and promote his or her welfare.

44.2 Ensure that all relevant professionals (those who have been involved in the child's life) are invited and able to attend, as well as those who are likely to be involved in future work with the child and family. In complex cases, you should consider whether to invite a professional who has expertise in the particular type of harm suffered by the child or in a child's particular condition, for example, a disability or long term illness. In all cases, the most relevant person from each agency should be invited.

44.3 Consider whether to seek advice from, or have present, a medical professional who can present the medical information in a manner which can be understood by conference attendees and enable such information to be evaluated from a sound evidence base.

44.4 Ensure the parents are invited and helped to participate. Family members should be given the child protection conference reports in advance of the conference and they should be written in their preferred language. Where necessary, you should discuss with the conference chair (who may wish to discuss with police officers) whether it may be necessary to exclude one or more family members from all or part of the conference. It may not be possible for all family members to be present at the same time, and the extent and manner of involvement of family members should be informed by what is known about them.

44.5 Discuss with the conference chair whether any steps are required to protect professional staff from intimidation either in the conference or after it, perhaps through police or legal action, and initiate this action if necessary.

44.6 Ensure that the decisions are recorded in the Outcome of the s47 Enquiries Record (Department of Health, 2002c), the reasons for them and what actions to be taken by whom and by when.

SOCIAL WORKERS SHOULD...

45.1 Involve the child in a way appropriate to their age and understanding. This includes talking to them about the purpose of the

conference, the means by which they want to express their views (including by attending), as well as what they want said to whom and sharing the conference reports with them in advance. Some children may not understand what has been happening to them and may therefore find it difficult to understand what you are telling them. Others may be very clear but may not have been able to talk to a trusted adult or may not have been listened to. All are likely to have suffered emotional abuse. This means that you should make sure before any discussions that the child knows he or she is now safe.

45.2 Involve the parents as appropriate and share your report with them in advance of the conference.

45.3 Bring information from all sources together into a systematic chronology. Bring to the chair's attention, for resolution at the conference, any contradictory information.

45.4 Prepare a report for the Child Protection Conference (Department of Health, 2002c).

GPS AND/OR MEDICAL CONSULTANTS SHOULD...

46.1 Closely collaborate with the member of staff in the PCT or Trust responsible for drawing up the report for the child protection conference especially where the child's medical history is complex.

46.2 Where the child is an in-patient, consider with ward staff and colleagues in the core agencies how best to ensure safe transfer of the child to primary care services, at the appropriate point.

46.3 Make every effort to attend the child protection conference.

ALL PRACTITIONERS SHOULD...

47.1 Contribute to your agency's written report in advance of the conference, which sets out the nature of involvement of staff at the agency with the family.

47.2 Consider, with the conference chair, who may wish to involve the police in these discussions, whether your report can and should be shared with the parents, and if so, when.

47.3 Where invited, attend the conference, and take a full part in decision making.

WHAT HAPPENS AT A CHILD PROTECTION CONFERENCE?

48 The conference should decide whether the child is at continuing risk of significant harm, and whether he or she therefore requires a child protection plan to be put in place, when determining whether to place

the child's name on the child protection register. It may be decided, where the child is not considered to be at risk of continuing harm, that his or her name will not be placed on the register. In this situation, consideration should be given to the child's needs and what future help would assist the family in responding to them. Where appropriate, a child in need plan should be drawn up and reviewed at regular intervals of no more than every six months (Paragraphs 4.33 and 4.36, Assessment Framework).

49 Where a child's name is placed on the register, **the act of registration itself confers no protection on a child**, and should always be accompanied by a child protection plan. It is the responsibility of the conference to consider and make recommendations on how agencies, professionals and the family should work together to ensure that the child will be safeguarded from harm in the future. This should enable both professionals and the family to understand exactly what is expected of them and what they can expect of others. Specific tasks include the following:

- appoint the lead agency (either a local authority or the NSPCC) and a key worker, who should be a member of staff of the lead agency;
- identify the membership of a core group of professionals and family members who will develop and implement the child protection plan as a detailed working tool;
- establish how the children, parents (including all those with parental responsibility) and wider family members should be involved in the ongoing assessment, planning and implementation process, and the support, advice and advocacy available to them;
- establish timescales for meetings of the core group, production of a child protection plan, and for child protection review meetings;
- identify in outline what further core and specialist assessments of the child and family are required to make sound judgements on how best to safeguard the child and promote his or her welfare;
- outline the child protection plan (Department of Health, 2002c), especially identifying what needs to change in order to safeguard the child. The plan should:
 - identify factors associated with the likelihood of the child suffering significant harm and ways in which the child can be protected, based on the current findings from the assessment and information held from any previous involvement with the child and family;
 - establish short-term and longer-term aims and objectives that are clearly linked to reducing the likelihood of harm to the child and promoting the child's welfare, including contact with family members;





- be clear about who will have responsibility for what actions – including actions by family members – within what specified timescales;
 - outline ways of monitoring and evaluating progress against the plan; and
 - be clear about which professional is responsible for checking that the required changes have taken place, and what action will be taken, by whom, when they have not.
- ensure that there is a contingency plan in place if agreed actions are not completed and/or circumstances change, for example if a carer fails to achieve what has been agreed, a court application is not successful or a parent removes the child from a place of safety;
 - clarify the different purpose and remit of the core group and the child protection review conference; and
 - agree a date for the first child protection review conference, and under what circumstances it might be necessary to convene the conference before that date.

PRE-BIRTH CHILD PROTECTION CONFERENCE

50 Where a core assessment under s47 of the Children Act 1989 gives rise to concerns that an unborn child may be at future risk of significant harm, it may be necessary for social services to convene an initial child protection conference prior to the child's birth. Such a conference should have the same status, and proceed in the same way, as other initial child protection conferences, including decisions about registration. The involvement of midwifery services is vital in such cases.

WHAT HAPPENS AFTER THE CHILD PROTECTION CONFERENCE IF CHILD'S NAME IS PLACED ON THE REGISTER?

THE NAMED KEYWORKER SHOULD...

51.1 Take a lead role in the core group as set out in *Working Together*, including ensuring that there is a written record of the action agreed at meetings, and decisions taken, and updating the child protection plan as necessary (Department of Health, 2002c).

51.2 Complete the core assessment within a maximum of 35 working days. Focus particularly on those areas highlighted by the child protection conference as requiring further exploration and understanding. Recognise that some specialist assessments may not be able to be completed within this period, or it may only become clear that certain types of assessments are required part way

through or at the end of the core assessment, particularly when the child's needs are very complex.

51.3 Analyse the findings of the assessment to provide an understanding of the child's needs and parenting capacity to respond appropriately to these needs within their family context and inform planning, case objectives and the nature of service provision (in accordance with Chapter 4 of the *Assessment Framework*). This understanding will not only refine the child protection plan, but it will also inform decision making at the first child protection review conference.

51.4 Complete the Core Assessment Record (Department of Health, 2002c).

THE CORE GROUP SHOULD...

52.1 Be led by the named keyworker, and include the child if appropriate, family members, and professionals or foster carers who will be working with the family.

52.2 Arrange for the provision of appropriate services whilst awaiting the completion of any specialist assessment(s).

52.3 Take responsibility, as a group, for developing the child protection plan as a detailed working tool, and implementing it, based on the outline plan agreed at the initial child protection conference. It should be refined as necessary, and the progress of the child and family members should be monitored against objectives specified in the plan.

52.4 Provide an important forum for working with parents, wider family members, and children of sufficient age and understanding. It can be difficult for parents to agree to a child protection plan within the confines of a formal conference. Their agreement may be secured later when details of the plan are negotiated in the core group. Sometimes there may be conflicts of interest between family members who have a relevant interest in the work of the core group. The child's best interests should always take precedence over those of other family members.

52.5 Meet for the first time within 10 working days of the initial child protection conference to develop in more detail the outline child protection plan and decide what further steps are required, by whom, to complete the core assessment on time. Thereafter, core groups should meet sufficiently frequently to facilitate working together, monitor actions and outcomes as set out in the child protection plan, and make any alterations as the child's and family members' circumstances change.

ALL OTHER PROFESSIONALS SHOULD...

53.1 Liaise closely with social services in gathering relevant historical material and integrating this within an assessment of the child's developmental needs and the capacity of their parents to respond to these needs.

53.2 Use information gained during core assessment, including capacity for change, to inform decisions about child's safety and future work with child and family.

53.3 Undertake specialist assessments and provide reports to the named keyworker.

PLANNING

54 The plan must focus on achieving improved developmental outcomes for the child and ensuring the child is safe, even though services may be provided to a number of family members as part of the plan. The complexity or severity of the child's needs will determine the scope and detail of the child protection plan.

55 In the plan, you should address both immediate and longer-term needs, with timescales that are neither too short nor unachievable. Identify the services required and the agencies involved, including who carries lead responsibility for ensuring which components of the plan are carried forward.

THE NAMED KEYWORKER SHOULD...

56.1 Based on the outline child protection plan prepared by the child protection conference, together with the core group members, draw up a child protection plan based on the findings of the assessment. This plan should follow the dimensions relating to a child's developmental needs, parenting capacity, and family and environmental factors and draw on knowledge about effective interventions across agencies and age ranges (Department of Health, 2002c).

56.2 Ensure that, wherever possible, the child or young person and relevant family members are involved in the drawing up of the plan.

56.3 Discuss this plan in detail with the relevant professionals, obtain their agreement to it and commitment to providing the necessary services.

56.4 Draw up the child protection plan in such a way that it makes it possible to see whether planned action has occurred and to identify the effectiveness of interventions. Provide reasonable objectives for work with a child and family, in relation to a child's developmental needs, in order to achieve improvements for the child.

OTHER PROFESSIONALS SHOULD...

57.1 Discuss the developing child protection plan with the named keyworker, and agree its content and any commitments for your organisation.

57.2 Ensure that you are able to deliver on any relevant commitments within the child protection plan, or if this is not possible that these commitments are renegotiated.

INTERVENTION

58 In deciding how to intervene, including what services to offer, you should also draw on evidence about what is likely to work best to bring about good outcomes for the child. It is important that services are provided to give the child and family the best chance of achieving the required changes. If a child cannot be cared for safely by his or her carer(s) then she or he will have to be placed elsewhere whilst work is being undertaken with the child and family. Irrespective of where the child is living, interventions should specifically address:

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

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

- action to make a child safe;
- action to help promote a child's health and development;
- action to help a parent/carer in safeguarding a child and promoting his or her welfare;
- therapy for an abused child; and
- support or therapy for a perpetrator of abuse.





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

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

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

63 More information to assist with making decisions about interventions is available in the Chapter 4 of the *Assessment Framework* and the accompanying practice guidance (Department of Health, 2000).

THE NAMED KEYWORKER SHOULD...

64.1 Undertake work with the child and family in accordance with the child protection plan.

64.2 Liaise with all professionals providing services to the child and family to keep up to date with progress and ensure each professional is aware of what the others are achieving as part of taking forward the agreed plan.

OTHER PRACTITIONERS SHOULD...

65.1 Provide services according to the agreed plan and where necessary undertake specialist assessments to inform the review of the plan.

65.2 Be involved in considering the relative importance of a number of different factors, including where a child has been separated from his or her birth family, the level of hopefulness and the presence of factors associated with failure of reunification, based on sound research evidence.

65.3 You may also be asked to prepare reports to courts about the likely effect of specific interventions, or their success with the carers.

CHILD PROTECTION REVIEW CONFERENCE

66 The purpose of the child protection review is to review the safety, health and development of the child against the planned objectives set out in the child protection plan; to ensure that the child continues to be safeguarded; and to consider whether the child protection plan should continue to be in place or should be changed. The reviewing of the child's progress and the effectiveness of interventions are critical to achieving the best possible outcomes for the child.

67 Every review should consider explicitly whether the child continues to be at risk of significant harm, and hence continues to need safeguarding through adherence to a formal child protection plan. If not, then the child's name may be removed from the child protection register. The same Area Child Protection Committee (ACPC) decision-making procedure should be used to reach a judgement on de-registration as is used at the initial child protection conference in respect of registration. As with initial child protection conferences, your ACPC procedures should specify a required quorum for attendance at review conferences.

SOCIAL SERVICES MANAGERS SHOULD...

68.1 Ensure that the first child protection review conference is convened to take place within three months of the initial child protection conference, and that further reviews are convened at intervals of not more than six months for as long as the child's name remains on the child protection register. Where necessary, reviews should be brought forward to address changes in the child's circumstances.

68.2 Ensure that the conference is scheduled so that those most involved with the child and family are able to attend, in the same way as at an initial child protection conference.

68.3 Ensure that the outcome of the review meeting is recorded, including whether the child's name is to be removed from the

register, and any changes to the child protection plan (Department of Health, 2002c).

68.4 Ensure that if a child's name is removed from the register, as a minimum, all those agencies' representatives who were invited to attend the initial child protection conference that led to the registration are notified.

THE NAMED KEYWORKER SHOULD...

69.1 Consider, with the Chair of the review conference, how best to ensure the child's participation, the appropriate involvement of all agencies and individuals and supervision and oversight by responsible managers.

69.2 Prepare a report for the child protection review conference.

69.3 Where the child's name is removed from the register, discuss with the parents and the child what services might be wanted and required. This discussion should be based upon the re-assessment of the child's needs within his or her family, since the child may still require additional support and services. De-registration should never lead to the automatic withdrawal of help.

69.4 If, after de-registration, services continue to be provided by social services a child in need plan should be drawn up and reviewed at intervals of not more than six months until the case is closed. The child, their family members and relevant professionals should be involved in the development of the plan.

ALL PRACTITIONERS SHOULD...

70.1 Produce reports for the child protection review conference, which together will provide an overview of work undertaken by family members and professionals, and evaluate the impact on the child's welfare against the objectives set out in the child protection plan.

70.2 Attend the review meeting, where appropriate.

WHEN MAY A CHILD'S NAME BE REMOVED FROM THE REGISTER?

80 A child's name may be removed from the register:

- as a result of a child protection review meeting deciding that the child is no longer in need of safeguarding via a child protection plan;
- if the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move and de-registration may only take place after a decision by this conference;

- when the child has reached 18 years of age, has died or has permanently left the UK.

WHAT HAPPENS IF A CHILD DIES?

81 If a child dies, and abuse or neglect is known to be a factor in that death, the ACPC will conduct a review into the involvement with the child and family of agencies and professionals to establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children, identify clearly what those lessons are, and improve inter-agency working. The ACPC may also conduct a review in other cases where a child has sustained a serious injury or serious impairment to health or development, and the case gives rise to concerns about inter-agency working to protect children. More information about the serious case review process can be found in *Working Together*, Chapter 8.

ALL AGENCIES SHOULD...

82.1 Carry out a management review of their agency's involvement in the case.

82.2 Contribute to the process of agreeing the report.

ALL PROFESSIONALS SHOULD...

83.1 Consider together whether there are any other children at risk of harm who need safeguarding, e.g. siblings, other children in an institution where abuse is alleged.

83.2 Provide a report to your own agency about your involvement with the child and family. This report should be as full as possible. It will be used by the agency to draw up a report of all involvement with the child by its staff.

83.3 Contribute to the process of your agency producing its management report to the review.

DESIGNATED HEALTH PROFESSIONALS SHOULD...

84.1 Review and evaluate the practice of all involved health professionals and providers within the Primary Care Trust area. This may involve reviewing the involvement of individual practitioners and trusts, and also advising named professionals and managers who are compiling reports for the review.



USE OF QUESTIONNAIRES AND SCALES TO EVIDENCE ASSESSMENT AND DECISION MAKING

1 The Strengths and Difficulties Questionnaires (Goodman et al, 1997; Goodman et al, 1998). These scales are a modification of the very widely used instruments to screen for emotional and behavioural problems in children and adolescents – the Rutter A + B scales for parents and teachers. Although similar to Rutter's, the Strengths and Difficulties Questionnaires' wording was re-framed to focus on a child's emotional and behavioural strengths as well as difficulties. The actual questionnaires incorporate five scales: pro-social, hyperactivity, emotional problems, conduct (behavioural) problems, and peer problems. In the pack, there are versions of the scales to be completed by adult caregivers, or teachers for children from age 3 to 16, and children between the ages of 11 and 16. These questionnaires have been used with disabled children and their teachers and carers. They are available in 40 languages on the following website: <http://www.sdqinfo.com>

2 The Parenting Daily Hassles Scale (Cronic and Greenberg, 1990; Cronic and Booth, 1991). This scale aims to assess the frequency and intensity/impact of 20 potential parenting 'daily' hassles experienced by adults caring for children. It has been used in a wide variety of research studies concerned with children and families – particularly families with young children. It has been found that parents (or caregivers) generally like filling it out, because it touches on many aspects of being a parent that are important to them.

3 The Recent Life Events Questionnaire (Taken from Brugha et al, 1985) helps to define negative life events over the last 12 months, but could be used over a longer timescale, and significantly whether the respondent thought they have a continuing influence. Respondents are asked to identify which of the events still affects them. It was hoped that use of the scale will:

- result in a fuller picture of a family's history and contribute to greater contextual understanding of the family's current situation;
- help practitioners explore how particular recent life events have affected the carer and the family;
- in some situations, identify life events which family members have not reported earlier.

4 The Home Conditions Assessment (Davie et al, 1984) helps make judgements about the context in which the child was living, dealing with questions of safety, order and cleanliness which have an important bearing where issues of neglect are the focus of concern. The total score has been found to correlate highly with indices of the development of children.

5 The Family Activity Scale (derived from the Child-Centredness Scale, Smith, 1985) gives practitioners an opportunity to explore with carers the environment provided for their children, through joint activities and support for independent activities. This includes information about the cultural and ideological environment in which children live, as well as how their carers respond to their children's actions (for example, concerning play and independence). They aim to be independent of socio-economic resources. There are two separate scales; one for children aged 2–6, and one for children aged 7–12.

6 The Alcohol Scale. This scale was developed by Piccinelli et al (1997). Alcohol abuse is estimated to be present in about 6% of primary carers, ranking it third in frequency behind major depression and generalised anxiety. Higher rates are found in certain localities, and particularly amongst those parents known to social services. Drinking alcohol affects different individuals in different ways. For example, some people may be relatively unaffected by the same amount of alcohol that incapacitates others. The primary concern therefore is not the amount of alcohol consumed, but how it impacts on the individual and, more particularly, on their role as a parent. This questionnaire has been found to be effective in detecting individuals with alcohol disorders and those with hazardous drinking habits.

7 Adult Wellbeing Scale (Irritability, Depression, Anxiety [IDA] Scale, Snaith et al, 1978). This scale, which was based on the Irritability, Depression and Anxiety Scale, was devised by a social worker involved in the pilot. The questions are framed in a 'personal' fashion (i.e. I feel, my appetite is...). This scale looks at how an adult is feeling in terms of their irritability, depression and anxiety. The scale allows the adult to respond from four possible answers, which enables them some choice, and therefore less restriction. This could enable the adult to feel more empowered.

8 The Adolescent Wellbeing Scale (Self-rating Scale for Depression in Young People, Birlerson, 1980). It was originally validated for children aged between 7 and 16. It involves 18 questions each relating to different aspects of a child or adolescent's life, and how they feel about these. As a result of the pilot the wording of some questions was altered in order to be more appropriate to adolescents. Although children as young as seven and eight have used it, older children's thoughts and beliefs about themselves are more stable. The scale is intended to enable practitioners to gain more insight and understanding into how an adolescent feels about their life.

9 The HOME Inventory (Cox and Walker, 2002) assessment through interview and observation provides an extensive profile of the context of care provided for the child and is a reliable approach to assessment of parenting. It gives a reliable account of the parents' capacities to provide learning materials, language stimulation, and appropriate physical environment, to be responsive, stimulating, providing adequate modelling variety and acceptance. A profile of needs can be constructed in these areas, and an analysis of how considerable the changes would need to be to meet the specific needs of the significantly harmed child; and the contribution of the environment provided by the parents to the harm suffered. The HOME Inventory has been used extensively to demonstrate change in the family context as a result of intervention, and can be used to assess whether intervention has been successful.

10 The Family Assessment (Bentovim and Bingley Miller, 2001). The various modules of the Family Assessment, which include an exploration of family and professional views of the current situation, the adaptability to the child's needs, and quality of parenting, various aspects of family relationships and the impact of history, provide a standardised evidence based approach to current family strengths and difficulties which have played a role in the significant harm of the child. They also provide an approach in assessing the capacity for change, resources in the family to achieve a safe context for the child, and the reversal of family factors which may have played a role in significant harm, and aiding the recovery and future health of the child. The Family Assessment profile provides it by its qualitative and quantitative information on the parents' understanding of the child's state, and the level of responsibility they take for the significant harm, the capacity of the parents to adapt to the children's changing needs in the past and future, their abilities to promote development, provide adequate guidance, care and manage conflict, to make decisions and relate to the wider family and community. Strengths and difficulties in all these areas are delineated, the influence of history, areas of change to be achieved, and the capacities of the family to make such changes.

RELEVANT QUESTIONNAIRES AND SCALES

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LEGISLATIVE FRAMEWORK

LOCAL GOVERNMENT ACT 2000

1 Local authorities have a corporate responsibility to address the needs of children and young people living in their area. The Local Government Act 2000 sets out a broad cross-government expectation that there should be a concerted aim to improve the wellbeing of people and communities. To achieve this, there should be effective joint working by education, social services, housing and leisure, in partnership with health, police and other statutory services and the independent sector.

THE CHILDREN ACT 1989

2 The Children Act 1989 places a duty on Councils with Social Services Responsibilities (CSSRs) to promote and safeguard the welfare of children in need in their area.

It shall be the general duty of every local authority –

- *To safeguard and promote the welfare of children within their area who are in need; and*
- *So far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.*

Children Act 1989 s17(1)

3 The primary focus of legislation about children in need is on how well they are progressing and whether their development will be impaired without the provision of services (s17(10) Children Act 1989).

4 It also places a specific duty on other local authority services and health bodies to co-operate in the interests of children in need in s27. Section 322 of the Education Act 1996 places a duty on social services to assist the local education authority where any child has special educational needs.

Where it appears to a local authority that any authority or other person mentioned in sub-section (3) could, by taking any specified action, help in the exercise of any of their functions under this Part, they may request the help of that other authority or persons, specifying the action in question. An authority whose help is so requested shall comply with the request if it is compatible with their own statutory or other duties and obligations and does not unduly prejudice the discharge of any of their functions.

The persons are –

- (a) any local authority;*
- (b) any local education authority;*
- (c) any local housing authority;*
- (d) any health authority, special health authority, Primary Care Trust or National Health Services Trust; and*
- (e) any person authorised by the Secretary of State for the purpose of this section.*

Children Act 1989 s27

5 Under s47 of the Children Act 1989, the same agencies are placed under a similar duty to assist local authorities in carrying out enquiries into whether or not a child is at risk of significant harm:

Section 47 places a duty on –

- (a) any local authority;*
- (b) any local education authority;*
- (c) any housing authority;*
- (d) any health authority, special health authority, Primary Care Trust or National Health Service Trust; and*
- (e) any person authorised by the Secretary of State*

to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

6 Under s17 of the Children Act 1989, CSSRs carry lead responsibility for establishing whether a child is in need and for ensuring services are provided to that child as appropriate. This does not require CSSRs themselves necessarily to be the provider of such services.

7 Section 17(5) of the Children Act 1989 enables the CSSR to make arrangements with others to provide services on their behalf.

Every local authority –

- (a) Shall facilitate the provision by others (including in particular voluntary organisations) of services which the authority have power to provide by virtue of this section, or section 18, 20, 23 or 24; and*
- (b) May make such arrangements as they see fit for any person to act on their behalf in the provision of any such service.*

Children Act 1989 s17(5)

EMERGENCY PROTECTION POWERS

8 There are a range of powers available to local authorities and their statutory partners to take emergency action to safeguard children:

EMERGENCY PROTECTION ORDERS

The court may make an emergency protection order under s44 of the Children Act 1989 if it is satisfied that there is reasonable cause to believe that a child is likely to suffer significant harm if:

- he is not removed to accommodation; or
- he does not remain in the place in which he is then being accommodated.

An emergency protection order may also be made if s47 enquiries are being frustrated by access to the child being unreasonably refused to a person authorised to seek access, and the applicant has reasonable cause to believe that access is needed as a matter of urgency:

- an emergency protection order gives authority to remove a child, and places the child under the protection of the applicant for a maximum of eight days (with a possible extension of up to seven days).

EXCLUSION REQUIREMENT

The Court may include an exclusion requirement in an emergency protection order or an interim care order (s38(a) and 44(a) of the Children Act 1989). This allows a perpetrator to be removed from the home instead of having to remove the child. The Court must be satisfied that:

- there is reasonable cause to believe that if the person is excluded from the home in which the child lives, the child will cease to suffer, or cease to be likely to suffer, significant harm or that enquiries will cease to be frustrated; and
- another person living in the home is able and willing to give the child the care which it would be reasonable to expect a parent to give, and consents to the exclusion requirement.

POLICE PROTECTION POWERS

Under s46 of the Children Act 1989, where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, he may:

- remove the child to suitable accommodation and keep him or her there; or
- take reasonable steps to ensure that the child's removal from any hospital, or other place in which the child is then being accommodated is prevented.

No child may be kept in police protection for more than 72 hours.

HOMELESSNESS ACT 2002

9 Under s12 of the Homelessness Act 2002, housing authorities are required to refer homeless persons with dependent children who are ineligible for homelessness assistance or are intentionally homeless to social services as long as the person consents. If homelessness persists, any child in the family could be in need. In such cases, if social services decides the child's needs would be best met by helping the family to obtain accommodation, they can ask the housing authority for reasonable assistance in this and the housing authority must respond.

RECORDING

10 The exemplars (Department of Health, 2002b and 2002c) produced to support the implementation of the Integrated Children's System illustrate how social services and other agencies can record information about children in need and their families. The appropriate record to use at the different stages of working with children and families has been referenced throughout this guidance.

INFORMATION SHARING

1 This guidance is about sharing information for the purposes of safeguarding and promoting the welfare of children. Sharing of information amongst practitioners working with children and their families is essential. In many cases it is only when information from a range of sources is put together that a child can be seen to be in need or at risk of harm.

2 You may be anxious about the legal or ethical restrictions on sharing information, particularly with other agencies. You should be aware of the law and should comply with the code of conduct or other guidance applicable to your profession. These rarely provide an absolute barrier to disclosure. You should be prepared to exercise your judgement. A failure to pass on information that might prevent a tragedy could expose you to criticism in the same way as an unjustified disclosure.

3 A decision whether to disclose information may be particularly difficult if you think it may damage the trust between you and your patient or client. Wherever possible you should explain the problem, seek agreement and explain the reasons if you decide to act against a parent or child's wishes. It is often helpful to discuss such concerns with a senior colleague, designated professional, or, if you are a working in the NHS or local authority social services, your Caldicott Guardian.

WHAT ARE THE LEGAL RESTRICTIONS?

4 The decision whether to disclose information may arise in various contexts. You may have a niggling concern about a child that might be allayed or confirmed if shared with another agency. You may be asked for information in connection with an assessment of a child's needs under s17 of the Children Act 1989 or an enquiry under s47 of that Act or in connection with court proceedings. In all cases the main restrictions on disclosure of information are:

- common law duty of confidence;
- Human Rights Act 1998;
- Data Protection Act 1998.

5 Each of these has to be considered separately. Other statutory provisions may also be relevant. But in general, the law will not prevent you from sharing information with other practitioners if:

- those likely to be affected consent; or
- the public interest in safeguarding the child's welfare overrides the need to keep the information confidential; or
- disclosure is required under a court order or other legal obligation.

COMMON LAW DUTY OF CONFIDENCE

6 The circumstances in which a common law duty of confidence arises have been built up in case law over time. The duty arises when a person shares information with another in circumstances where it is reasonable to expect that the information will be kept confidential.

The courts have found a duty of confidence to exist where –

- *a contract provides for information to be kept confidential;*
- *there is a special relationship between parties, such as patient and doctor, solicitor and client, teacher and pupil;*
- *an agency or government department, such as Inland Revenue, collects and holds personal information for the purposes of its functions.*

The duty is not absolute. Disclosure can be justified if –

- *the information is not confidential in nature;*
- *the person to whom the duty is owed has expressly or implicitly authorised the disclosure;*
- *there is an overriding public interest in disclosure;*
- *disclosure is required by a court order or other legal obligation.*

IS THE INFORMATION CONFIDENTIAL?

7 Some kinds of information, such as medical records and communications between doctor and patient, are generally recognised as being subject to a duty of confidence. Other information may not be, particularly if it is trivial or readily available from other sources or if the person to whom it relates would not have an interest in keeping it secret. For example, a social worker who was concerned about a child's whereabouts might telephone the school to establish whether the child was in school that day.

MAINTAINING CONFIDENTIALITY

8 As a general rule you should treat all personal information you acquire or hold in the course of working with children and families as confidential and take particular care with sensitive information.

DISCLOSURE BY CONSENT

9 There will be no breach of confidence if the person to whom a duty of confidence is owed consents to the disclosure. Consent can be express (that is orally or in writing) or can be inferred from the circumstances in which the information was given (implied consent).

- **Whose consent is required?** The duty of confidence is owed to the person who has provided information on the understanding it is to be kept confidential and, in the case of medical or other records, the person to whom the information relates.

- **Has consent been given?** You do not need express consent if you have reasonable grounds to believe that the person to whom the duty is owed understands and accepts that the information will be disclosed. For example, a person who refers an allegation of abuse to a social worker would expect that information to be shared on a 'need to know' basis with those responsible for following up the allegation. Any one who receives information, knowing it is confidential, is also subject to a duty of confidence. Whenever you give or receive information in confidence you should ensure there is a clear understanding as to how it may be used or shared.
- **Should I seek consent?** If you are in doubt as to whether a disclosure is authorised it is best to obtain express consent. But you should not do so if you think this would be contrary to a child's welfare. For example, if the information is needed urgently the delay in obtaining consent may not be justified. Seeking consent may prejudice a police investigation or may increase the risk of harm to the child.
- **What if consent is refused?** You will need to decide whether the circumstances justify the disclosure, taking into account what is being disclosed, for what purposes and to whom.

DISCLOSURE IN THE ABSENCE OF CONSENT

10 The law recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others.

11 The key factor in deciding whether or not to disclose confidential information is **proportionality**: is the proposed disclosure a proportionate response to the need to protect the welfare of the child. The amount of confidential information disclosed, and the number of people to whom it is disclosed, should be no more than is strictly necessary to meet the public interest in protecting the health and wellbeing of a child. The more sensitive the information is, the greater the child-focused need must be to justify disclosure and the greater the need to ensure that only those professionals who have to be informed receive the material ('the need to know basis').

The 'Need to Know' Basis

Relevant Factors:

- what is the purpose of the disclosure?
- what are the nature and the extent of the information to be disclosed?
- to whom is the disclosure to be made (and is the recipient under a duty to treat the material as confidential)?
- is the proposed disclosure a proportionate response to the need to protect the welfare of a child to whom the confidential information relates?

IS THERE A DIFFERENCE BETWEEN DISCLOSING INFORMATION WITHIN YOUR OWN ORGANISATION OR TO ANOTHER ORGANISATION?

12 The approach to confidential information should be the same whether any proposed disclosure is internally within one organisation (e.g. within a school, or within social services) or between agencies (e.g. from a teacher to a social worker).

13 The need to disclose confidential information to others within your own organisation will arise more frequently than will be the case for inter-agency disclosure. For example a teacher will need to discuss confidential information with the Year Head and the Head Teacher more frequently than with a social worker. Pupils and their parents would expect such discussions to take place within the school, so there will usually be implied consent. But if not (e.g. if you disclose information that a child has asked you to keep secret) you will have to decide whether the circumstances justify the disclosure.

WHAT IF THE DUTY IS TO A CHILD OR YOUNG PERSON?

14 A duty of confidence may be owed to a child or young person in their own right. A young person aged 16 or over, or a child under 16 who has the capacity to understand and make their own decisions, may give (or refuse) consent to a disclosure. Otherwise a person with parental responsibility should consent on their behalf.

THE HUMAN RIGHTS ACT 1998

15 Article 8 of the European Convention on Human Rights (which forms part of UK law under the Human Rights Act 1998) recognises a right to respect for private and family life.

8.1 *Everyone has the right to respect for his private and family life, his home and his correspondence.*

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

Article 8 ECHR

16 The right is not absolute. Disclosing confidential information to protect the welfare of a child could cause considerable disruption to a person's private or family life. This may, however, be justified by Article 8(2) if it is necessary to prevent crime or to protect the health and welfare of a child. Essentially it is the same 'proportionality' test as applies to the common law duty of confidence.

17 If sharing information is justified under the common law duty of confidence and does not breach the data protection requirements or any other specific legal requirements, it should satisfy Article 8.

THE DATA PROTECTION ACT 1998

18 The Data Protection Act 1998 regulates the handling of personal data. Essentially, this is information kept about an individual on a computer or on a manual filing system. The Act lays down requirements for the processing of this information, which includes obtaining, recording, storing and disclosing it.

19 If you are making a decision to disclose personal data you must comply with the Act, which includes the eight data protection principles. These should not be an obstacle if:

- you have particular concerns about the welfare of a child;
- you disclose information to social services or to another professional; and
- the disclosure is justified under the common law duty of confidence.

20 The first and second data protection principles are the most relevant.

The First Principle

Personal data shall be processed fairly and lawfully and, in particular shall not be processed unless –

- (a) at least one of the conditions in Schedule 2 is met and,*
- (b) in the case of sensitive personal data, at least one of the conditions in Schedule 3 is met.*

The Second Principle

Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.

21 'Fairness' is being open with people about how information about them is to be used and the circumstances in which it might be disclosed. Most organisations take steps to make people aware of their policy when they first obtain information from them, for example, by including it on forms or leaflets or by notices in waiting areas. There are a number of exceptions to this requirement, in particular, if the disclosure is for the prevention or detection of crime (which includes neglect or abuse of a child) or is required by a court order or a statute.

22 A condition in Schedule 2 must be met. Those conditions establish whether there is a legitimate reason for sharing information. They include:

- the data subject (the person to whom the data relates) consents;
- the disclosure is necessary for compliance with a legal obligation;
- it is necessary to protect the vital interests of the data subject;

- it is necessary for the exercise of a statutory function, or other public function exercised in the public interest (e.g. for the purposes of an s17 assessment or an s47 enquiry); and
- it is necessary for the purposes of legitimate interests pursued by the person sharing the information, except where it is unwarranted by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.

23 There is a condition to cover most situations where a practitioner shares information to safeguard a child's welfare. In particular, the last condition (legitimate interest) is relevant in all cases and involves a proportionality test very similar to that applied to breaches of confidence.

24 If the information being shared is sensitive personal data, then a condition in Schedule 3 must also be met. Sensitive personal data relates to the data subject's:

- racial or ethnic origins;
- political opinions;
- religious beliefs;
- membership of a trade union;
- physical or mental health or condition;
- sexual life;
- criminal offences.

25 The relevant conditions in Schedule 3 are:

- the data subject has explicitly consented to the disclosure;
- it is necessary to protect the vital interests of the data subject or another person where the data subject's consent cannot be given or is unreasonably withheld or cannot reasonably be expected to be obtained;
- it is necessary to establish, exercise or defend legal rights;
- it is necessary for the exercise of any statutory function; and
- it is in the substantial public interest and necessary to prevent or detect an unlawful act and obtaining express consent would prejudice those purposes.

26 'Legal rights' include a child's rights under the Human Rights Act 1998 and defending those rights could include disclosures between professionals to establish whether a child's welfare needed to be safeguarded. Exercise of a statutory function would cover sharing of information amongst social services and other agencies in connection with an s17 assessment or an s47 enquiry.

27 The second data protection principle requires that the purpose for which information is disclosed is not incompatible with the purpose for which it was obtained. But it can be for a different purpose if there is no direct conflict. Disclosures for prevention or detection of crime or required by a court order or a statute are exempt from this requirement.

28 If you need advice about the data protection requirements, you should contact the data protection compliance officer in your organisation or, if you do not have one, you can contact the Information Commissioner (www.dataprotection.gov.uk).

OTHER STATUTORY PROVISIONS

29 Sections 27 and 47 of the Children Act 1989 enable local authorities to request help from specified authorities (other local authorities, education authorities, housing authorities, NHS bodies) and places an obligation on those authorities to co-operate. A request could be for information in connection with an s17 assessment or an s47 enquiry. Neither provision would require an unjustified breach of confidence. But an authority should not refuse a request without considering all the circumstances.

30 Section 115 of the Crime and Disorder Act 1998 enables any person to disclose information to a relevant authority for any purposes of the Act if they would not otherwise have the power to do so. Relevant authorities include local authorities, NHS bodies and police authorities. The purposes of the Act broadly cover the prevention and reduction of crime and the identification or apprehension of offenders.

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READER INFORMATION

Work area	Policy
Document purpose	Best Practice Guidance
ROCR ref	Gateway Ref: 1384
Title	What To Do If You're Worried A Child Is Being Abused
Author	Department of Health COS(C)CNI
Publication date	19 May 2003
Target audience	Selected Police, Paediatricians, Social Workers working with children, Named and Designated Child Protection Professionals.
Circulation list	PCT CEs, NHS Trusts CEs, StHAs CEs, Local Authority CEs.
Description	This booklet has been developed to assist practitioners to safeguard and promote the welfare of children. It also contains an appendix to help practitioners with the legal issues affecting the sharing of information.
Cross ref	Framework for Assessment of Children in Need and their Families (2000), Working Together to Safeguard Children (1999)
Superseded docs	Child Protection – Medical responsibilities – Guidance to Doctors Working with Child Protection Agencies, Addendum to Working Together under the Children Act 1989; Child Protection: Guidance for Senior Nurses, health visitors, midwives and their managers & Appendix 5 entitled Individual cases flow chart in Working Together to Safeguard Children (p. 116)
Action required	NHS CEs to distribute to Child Protection named and designated professionals and LA CEs to children's services social workers.
Timing	By 10 June 2003
Contact Details	Nicola St. Clair-Newman VCI Response Team Room 123 Wellington House 133–155 Waterloo Road SE1 8UG 020 7972 1352 Nicola.St.Clair-Newman@doh.gsi.gov.uk
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