

## 9 ADDITIONAL PROCEDURES

### 9.1 INTRODUCTION

9.1.1 The following procedures are presented in alphabetical order.

### 9.2 ABUSE BY CHILDREN

#### SCOPE

9.2.1 The following procedures apply when there is an allegation or suspicion that a child has abused or is at risk of abusing another child or adult, including both those:

- Outside of the child's immediate household and
- Within her/his household e.g. sibling abuse

#### THRESHOLD FOR REFERRAL

##### Child victim

9.2.2 Severe harm may be caused to children by abusive and bullying behaviour of other children, which may be physical, sexual or emotional and such abuse must be taken as seriously as abuse perpetrated by an adult.

9.2.3 The same signs and symptoms that pertain to the abuse of children by adults are applicable to the abuse of children by other children.

9.2.4 The effect on the victim of intimidation and peer pressure by their abuser may make disclosure difficult for the victim.

9.2.5 In sexual abuse between children it is important to determine what is developmentally normal sexual experimentation and what is coercive (see 9.23 and 9.21 respectively).

9.2.6 Professionals must decide in the circumstances of each case whether or not behaviour directed at another child should be categorised as 'abusive' and it will be helpful to consider the following factors:

- Relative chronological and developmental age of the children (the greater the difference the more likely the behaviour should be defined as abusive)
- A differential in power or authority e.g. related to race or physical or intellectual vulnerability of the victim
- Actual behaviour (both physical and verbal factors must be considered)

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- Whether the behaviour could be described as age appropriate or involves inappropriate sexual knowledge or motivation
- Physical aggression, bullying or bribery
- The victim's experience and perception of the behaviour
- Attempts to ensure secrecy
- An assessment of the change in the behaviour over time (whether it has become more severe or more frequent)
- Duration and frequency of behaviour

9.2.7 When there is suspicion or an allegation of a child having sexually abused or being likely to sexually abuse another child (or an adult), it should be referred immediately to Children's Social Care or the CAIU.

### Adult victim

9.2.8 If allegations concern abuse of an adult by a child, the police would normally undertake the criminal investigation, but Children's Social Care should be advised of any allegation of abusive behaviour by a child, irrespective of the age of the victim.

9.2.9 Adult Care Services and/or Hertfordshire Partnership Trust should be informed and involved when a vulnerable adult is alleged to have been abused.

### Alleged abuser – a possible victim?

9.2.10 The possibility the alleged abuser is or was also a victim of abuse should be considered.

### Bullying

9.2.11 Bullying is a common form of deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for the victims to defend themselves.

9.2.12 Damage inflicted by bullying is often underestimated. It can cause considerable distress and affect health and development and in the extreme can cause significant harm, including self-harm. This could be via acts of omission or commission by an individual or institution.

9.2.13 Bullying takes many forms, but the three main types are physical (hitting, kicking, theft), verbal (racist or homophobic remarks, threats, name calling) and emotional e.g. isolating an individual from social activities. Perpetrators and victims may be male or female.

9.2.14 All settings in which children are provided with services or are living away from home are required to adopt policies to combat bullying (including cyberbullying via mobile phones or internet usage) and in the first instance, cases should be dealt with under such policies.

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- 9.2.15 When there are concerns about sexual abuse or serious or persistent physical or emotional abuse, referrals should be made to Children's Social Care or the Police.
- 9.2.16 Bullying may involve an allegation of crime (assault, theft, harassment) and this must be reported to the police at the earliest opportunity.

### Schools' role in recognition of abuse

- 9.2.17 Concerns about possible abuse by one child of another are frequently first considered within a school environment and it may frequently be unclear if the circumstances should be considered under child protection procedures or not.
- 9.2.18 When it is clear that the concern is one of child protection there should be **no delay** in the referral to Children's Social Care or the CAIU e.g. disclosure or witnessing of sexual abuse or allegation of physical assault.
- 9.2.19 When further assessment is required prior to deciding the extent and nature of the concerns, the school should undertake an evaluation of all relevant information is required to inform the extent and nature of the concerns and the appropriate response:
- An initial discussion should be held with each of the pupils involved and they should be given the opportunity to record or dictate, in their own words an account of what has happened
  - On the basis of the accounts given, the perceived level of distress experienced by the pupils and/or risk of further incident, consideration should be given to the need to separate alleged victim and perpetrator in the classroom or in the school and the possible need to send one or both home (for a defined period)
  - A written record of pertinent information including date and time of the incident and staff signature – a diagram / photo of the room / playground may be useful, as well as a description of who was present (potential witnesses)
  - It may be appropriate to seek an account of the incident from other pupils or staff named as being present
  - Provide the child with the opportunity to confirm the accuracy of the record and record any disagreement
- 9.2.20 The information gathered should be kept as a formal record of the incident and:
- Pupils involved given the opportunity to comment on the factual accuracy of this formal record and any disagreement recorded
  - Parents / carers of pupils involved should, without delay be informed of the incident, the initial action taken by the school and a meeting should be arranged so that they can be present when the pupils are formally interviewed about the incident by school staff:

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### RESPONSE

- 9.2.21 These procedures are **additional** to those that apply to all children.
- 9.2.22 The interests of the identified victim must always be the paramount consideration. However, whenever a child may have abused another, all agencies must be aware of their responsibilities to **both** individuals and multi-agency management of the case must reflect this.
- 9.2.23 It is likely that the abuser may pose a significant risk of harm to other children, have considerable needs themselves and may also be or have been the victim of abuse.

### Strategy discussions

- 9.2.24 On receipt of a referral to Children's Social Care, a decision should be taken if the threshold for s.47 enquiries has been reached. The police must be informed if a criminal offence may have been committed in line with normal child protection procedures (see [6.5](#))
- 9.2.25 When the decision is reached that the alleged behaviour does not constitute abuse and there is no need for further enquiry or criminal investigation, the details of the referral and the reasons for the decision must be recorded. In these circumstances consideration should be given to the need for any further assessment or support services, from any agency, for either child. In the case of a child's sexualised behaviour, consideration should be given to the use of multi-agency child in need meetings (see [9.2.46](#)).
- 9.2.26 If a decision is reached that the behaviour does constitute alleged abuse and the suspected abuser is a child, Children's Social Care must convene a strategy discussion (usually a meeting) within the s.47 time-scales (see [6.7](#))
- 9.2.27 In cases where the alleged perpetrator is below the age of criminal responsibility, those involved in the strategy discussion should agree whether police involvement in the enquiry is necessary.
- 9.2.28 When the children concerned are the responsibility of different local authorities, each must be represented at the strategy discussion, which will usually be convened and chaired by the authority in which the victim lives.
- 9.2.29 The strategy discussion must consider the needs of both children. It may be helpful for separate meetings to be convened for victim and alleged abuser.

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- 9.2.30 To ensure that both are supported through the process of the enquiry and that both their needs are fully assessed a different social worker may be allocated for the victim and the abuser, even when they live in the same household.
- 9.2.31 Strategy discussion/s should be convened and chaired by Children's Social Care and a record made. The following individuals should be invited to the meeting:
- Social worker for the child suspected or alleged to have abused another person
  - Social worker for the child alleged to have been abused
  - Social workers' first line manager/s
  - Police CAIU
  - YOT representative where the alleged abuser is aged ten or over
  - School representative/s (particularly if the concerns suggest that other children in the school setting may have been or may be at risk of being abused)
  - School nurse or other health services staff as required
  - Child protection school liaison officer
  - Education welfare service
  - Representatives of fostering or residential care as applicable
  - Any other professionals involved with the child (or where relevant the family) e.g. CAMHS
- 9.2.32 The discussion/s must plan in detail the respective roles of those involved in enquiries and ensure that:
- Information relevant to the protection needs of the alleged victim is gathered
  - Any criminal aspects of the abuse are investigated
  - Any information relevant to any abusive experiences and protection needs of the alleged perpetrator is obtained
- 9.2.33 In planning the investigation the following should be considered:
- Age of both children
  - Seriousness of the alleged incident
  - Effect on the victim and her/his own view of personal safety
  - Parental attitude and ability to protect their child
  - Arrangements to protect the victim and other children, especially where the victim and alleged perpetrator are in the same household or school class
  - Whether there is suspicion that the alleged abuser has also been abused

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- Whether there is reason to suspect that adults are also involved
  - The likelihood and desirability of criminal prosecutions taking place
- 9.2.34 When there is suspicion that the child is both an abuser and a victim of abuse, the strategy discussion must consider the order in which interviews will take place.
- 9.2.35 Where police decide to conduct a separate 'offender' interview, Children's Social Care will not normally be involved other than in performing any statutory responsibilities to the child e.g. as appropriate adult.
- 9.2.36 Throughout the enquiry, the immediate protection of the child/ren must be ensured, if that is necessary.

## OUTCOME OF ENQUIRIES

- 9.2.37 The outcome of enquiries is as described in [6.13](#). However, the position of the alleged victim and the alleged perpetrator must be considered separately.
- 9.2.38 If the information gathered in the course of enquiries suggests that the perpetrator is also a victim, or potential victim, of abuse including neglect, a child protection conference must be convened.
- 9.2.39 When there are no grounds for a child protection conference, but concerns remain regarding the child's sexually abusive behaviour, s/he will be considered as a child in need. In such cases, a multi-agency planning meeting should be held (see [9.2.46](#)).

## CHILD PROTECTION CONFERENCE

- 9.2.40 Standard conference procedures should be followed for the alleged abuser or the victim when the criteria are met (see [6.13](#)).
- 9.2.41 In addition for any conference about an alleged abuser:
- Consideration should be given to inviting a YOT representative to the conference of alleged abusers aged 10 or over, and informing the YOT of the meeting in the case of younger children
  - As well as carrying out all of its normal functions the child protection conference must consider how to respond to the child's needs as a possible abuser
- 9.2.42 Where the alleged abuser is not registered, consideration should be given to the need for services to address any abusive behaviour and the multi-agency responsibility to manage any risk, through the use of multi-agency child in need meetings (see [9.2.46](#)).

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### CRIMINAL PROCEEDINGS

- 9.2.43 The decision as to how to proceed with the criminal aspects of a case will be made by the police and the Crown Prosecution Service (CPS). This decision will take into account any recommendations of the YOT and the views of other professionals.
- 9.2.44 Best practice suggests that criminal proceedings should not be taken where:
- Criminalising certain types of behaviour may be detrimental to the interests of all concerned
  - It is inappropriate to pursue the criminal aspects of the case because the professionals are satisfied that sexual activity took place but that it was not abuse (see also [9.21 Sexual Exploitation](#) and [9.23 Underage Sexual Activity](#))

### MULTI AGENCY CHILD IN NEED MEETINGS

- 9.2.45 When there are insufficient grounds for holding a child protection conference, or where one has been held but a child protection plan was not implemented, a multi-agency approach will still be needed if the young abuser's needs are complex.
- 9.2.46 In such cases a multi-agency child in need (CIN) meeting should be convened by Children's Social Care to pool information, allocate roles and set a time-table for an assessment of the needs of the child and the risk posed by them, as well as to co-ordinate any other interim intervention.
- 9.2.47 The meeting should be chaired by the appropriate line manager and held **within**:
- Fifteen working days of the last strategy discussion or
  - Three months of the child protection conference which decided that a protection plan was not required
- 9.2.48 Those invited should include participants of the strategy discussions and representatives from health (including child and adolescent mental health services), school and any other appropriate service provider, the child and her/his parents / carers.
- 9.2.49 A plan should be agreed which:
- Defines the elements of a multi-agency assessment
  - Identifies any specialist assessments of the abusive behaviours
  - Addresses any immediate intervention required to minimise risk of future offending, including educational and accommodation needs

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- Co-ordinates the role of relevant agencies and identifies those responsible for specific actions
  - Defines timescales, expected outcomes and contingency arrangements
- 9.2.50 On completion of the assessment, the same forum should be reconvened (within three months) to consider the outcome and the use of a further child in need plan.
- 9.2.51 Intervention should be reviewed subsequently at multi-agency meetings at intervals of no more than six months. At the point of closure, the review should consider the possible need for long-term monitoring and the availability of advice and other services.
- 9.2.52 Each meeting should consider the need for relevant professionals to meet regularly prior to the next review, so as to ensure that the plan is progressed and contingency arrangements implemented if required.
- 9.2.53 Young people with inappropriate sexual behaviour re-entering the community following a custodial sentence or time in secure accommodation, or who move into an area from another also require such a multi-agency assessment and planning of intervention.

## 9.3 ABUSIVE IMAGES OF CHILDREN & INFORMATION COMMUNICATION TECHNOLOGY (ICT)

### DEFINITION

- 9.3.1 For the purposes of child protection, abusive images of children can be divided into:
- Those which are unlawful and
  - Material, which although lawful, would give cause for concern and indicate that the person possessing it may pose a risk to children

### Unlawful material

- 9.3.2 An abusive image of a child under the age of eighteen years old includes images in photographs, films, negatives, video tape, data stored on computers that can be converted into a photograph and 'pseudo-photographs' (images made by computers graphics, or other means, which appear to be a photograph). This also covers electronic images used by video phones and texting.
- 9.3.3 Possession of such material is an offence. Taking, showing or distributing such material amounts to a more serious offence.

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### Lawful material

- 9.3.4 Lawful material falls outside the above definition, but may involve children in an indecent or sexual context. This could include pictures, cartoons, literature or sound recordings e.g. books, magazines, audio cassettes, tapes, CDs.

### RECOGNITION

- 9.3.5 Abusive images may be found in the possession of those who use it for personal use or distributed to children as part of the grooming process.

### Use of the internet

- 9.3.6 The internet has become a significant tool in the distribution of abusive images of children, enabling ready access to such material. It may be downloaded and printed off in picture form or stored electronically on the hard drive of a computer, CD Rom, floppy disc, memory card / stick etc.
- 9.3.7 Some adults use it to establish contact with children with a view to grooming them for inappropriate or abusive relationships. This may be accomplished through 'chat rooms' or contact by e-mail and may constitute an offence under The Sexual Offences Act 2003.
- 9.3.8 Children may be encouraged to access abusive images of children themselves through using apparently innocent words in an internet search engine.
- 9.3.9 Parents may wish to seek advice from their internet service provider of software programmes to limit access to sites that may be unsuitable for children.
- 9.3.10 See contact details in appendix 2 for sources of advice on internet safety.

### RESPONSE

- 9.3.11 Parents should inform Police if they are aware that a child has been the recipient of any suspicious contact through the internet or in receipt of abusive images, as described above.
- 9.3.12 Police must be informed of any information that a person may be in possession of abusive images of children or have placed / accessed abusive images of children on the internet.

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- 9.3.13 Any information that a child may have been inappropriately contacted or approached, directly or via the internet, should also be passed to the Police.
- 9.3.14 The Paedophile Investigation Unit and/or the Child Exploitation and Online Protection (CEOP) Centre [www.ceop.gov.uk](http://www.ceop.gov.uk) can offer advice on matters of abusive images of children to other agencies.
- 9.3.15 Whenever the Police are informed of concerns that an individual may be involved in the creation, distribution or possession of abusive images of children, consideration must be given to the possibility that the individual might also be involved in the active abuse of children and her/his access to children should be established, including family and work settings.
- 9.3.16 The Police must inform Children's Social Care and a strategy discussion held whenever it is suspected a parent / carer or someone with access to children in other contexts e.g. employment or voluntary work:
- Is in possession of child abusive images of children and / or
  - Has taken, shown or distributed child abusive images of children and / or
  - Has used the internet to make inappropriate approaches to children
- 9.3.17 The strategy discussion must consider all access the individual has to children and initiate a s.47 enquiry whenever it is confirmed that a parent or carer of child/ren, or someone with access to child/ren has been involved in one or more of the activities detailed above.
- 9.3.18 See 14.1 for LSCB responsibility to raise awareness about the safe use of the internet by children.

## 9.4 CRIMINAL INJURIES COMPENSATION SCHEME

- 9.4.1 Children who are victims of crimes of violence (committed within or outside the family) may be entitled to criminal injuries compensation whether or not there has been a prosecution or conviction and even where there is no physical injury, as in cases of sexual assault.
- 9.4.2 The Criminal Injuries Compensation Authority (the Authority) considers applications for compensation under the Criminal Injuries Compensation Scheme (the Scheme) to those who suffer personal injuries directly attributable to a crime of violence (legal aid may be available to assist in submitting applications and deciding whether or not to accept awards).
- 9.4.3 CSF staff should consult the Police before initiating discussions with potential claimants.

## ADDITIONAL PROCEDURES

### 9.4.4 Conditions of the scheme are as follows:

- There is a minimum compensation award currently set at £1000 and the injury must be serious enough to qualify under the Scheme's criteria contained in the tariff of injuries, for an award of this amount to be paid
- The incident should have been reported to the Police unless there was good reason for not doing so; the Authority may withhold or reduce compensation if an applicant did not take, without delay, all reasonable steps to inform the Police or another appropriate authority, the circumstances of the injury
- There is a two year limitation period on making a claim which starts from the date of the incident, unless the Authority exercises its discretion to 'allow an application out of time' (for child abuse the Authority may be sympathetic to applications no matter how old)
- Compensation will not be paid unless the Authority are satisfied that the offender will not benefit from an award paid to a victim (on granting an award the Authority may appoint trustees to hold the compensation for the benefit of the child making such provisions for maintenance and education as necessary)
- Where the child and the person causing the injuries were living in the same household, (as members of the same family) at the time of the injuries, compensation will only be paid where the person responsible has been prosecuted (unless there are good reasons why not) and the Authority are satisfied that it would not be against the child's interests to make a payment; for the purposes of the Scheme an applicant is a child if s/he is under eighteen years of age when the application is determined (the Authority are always concerned, particularly in cases of sexual offences, to ensure that offenders do not benefit from awards)

## CONDUCTING CLAIMS BY CHILDREN

9.4.5 If the local authority holds parental responsibility Children's Social Care should help the child make the claim or initiate it on her/his behalf. The form should be completed by the social worker and approved by her/his manager. The local authority has no power to make a claim on behalf of a child unless s/he is subject to a Care Order.

9.4.6 If the child is looked after, but the local authority does not have parental responsibility, the person with parental responsibility should be approached about the making of a claim.

9.4.7 If this is inappropriate e.g. because that person caused the injuries, is cohabiting with the person who did or declines to initiate the claim, Children's Social Care should consider referring the child to an appropriate agency e.g. a solicitor or victim support.

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- 9.4.8 A child who has been the subject of a child protection conference may be eligible to apply. Advice and guidance therefore should be given to parents of the child about criminal injuries compensation.
- 9.4.9 When a child is not looked after or where the offence did not give rise to a child protection conference, the responsibility for advising that an application be made rests with the Police.
- 9.4.10 Further information about the Criminal Injuries Compensation Authority and an application form can be obtained from The Criminal Injuries Compensation Authority, Tay House, 300 Bath Street, Glasgow G2 4LN tel: 0800 3583601 or (for London and the South East of England) Morley House 26-30 Holborn Viaduct London EC1A 2JQ tel: 020 7842 6800 [www.cica.gov.uk](http://www.cica.gov.uk)

## 9.5 DOMESTIC VIOLENCE

### DEFINITION

- 9.5.1 Domestic violence is a broad description of abusive relationships that develop within the home / family environment where power is exercised to the detriment of at least one party. Responsibility for domestic violence rests with the perpetrator and without intervention, the evidence is that it is likely to get worse.
- 9.5.2 Such situations may involve threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who live in the same household or where one lives in the household and the other is a regular visitor e.g. partners, ex-partners and family members.
- 9.5.3 Domestic violence may be exacerbated by other factors e.g. mental illness, substance misuse (including alcohol), homelessness and housing need, pregnancy, new birth and separation.

### POSSIBILITY OF SIGNIFICANT HARM TO CHILD

- 9.5.4 If there is domestic violence, the implications for children (including the unborn child if the victim is pregnant) in the household must be considered since research indicates a strong link between domestic violence and all types of abuse and neglect. A key part of protecting children in a domestic violence context involves an assessment of the risk presented by the perpetrator. Any child witnessing domestic violence meets the threshold criterion for s.47 enquiries (see 6.3)
- 9.5.5 Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress.

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- 9.5.6 A child may also be the victim of domestic violence through her or his own involvement in a violent relationship e.g. a child may be involved in a relationship with a violent girlfriend / boyfriend.
- 9.5.7 Domestic violence can have a serious impact on a child's development and emotional well-being. Significant harm to the child as a result of domestic violence may arise from:
- The adverse psychological effect of witnessing or being aware of threats of, or actual, violence between adults
  - Physical injury, either by accident in the midst of a violent incident or by design from a violent adult, including harm to the unborn baby (assaults on pregnant women often involve punches / kicks directed at the abdomen)
  - A negative impact on victim's ability to look after her/his child/ren as a result of physical assaults and/or psychological abuse
  - Being drawn into violence or pressurised into concealing assaults
- 9.5.8 The child may also (as an adult) become an abuser.

## POSSIBLE INDICATORS OF DOMESTIC VIOLENCE TO VICTIM

- 9.5.9 Possible indicators of domestic violence in the victim include:
- Police domestic violence call outs
  - Evidence of single or repeated injuries with unlikely explanations
  - Criminal convictions and/or cautions
  - Frequent use of prescribed tranquillisers or pain medication
  - Injuries to breast, chest and abdomen especially during pregnancy
  - Evidence of sexual or frequent gynaecological problems
  - Frequent visits to GP with vague complaints or symptoms
  - Stress or anxiety disorders; isolation from friends, family or colleagues; depression, panic attacks or other symptoms; alcohol and/or drug abuse; suicide attempts or child acting out at school
  - Appearing frightened, ashamed or evasive; a partner who is extremely jealous or possessive; minimisation of violence accepting blame for 'deserving' the abuse
- 9.5.10 When a victim is not being seen alone, staff should also be alert to the following combination of signals:
- The victim waits for her/his partner to speak first
  - The victim glances at her/his partner each time s/he speaks, checking her/his reaction
  - The victim smoothes over any conflict
  - The partner speaks for most of the time

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- The partner sends clear signals to the victim, by eye / body movement, facial expression or verbally, to warn them
  - The partner has a range of complaints about the victim, which s/he does not defend
- 9.5.11 Consideration must also be given to young people who may themselves be in violent relationships.
- 9.5.12 Practitioners should be aware that some victims may face additional difficulty in disclosing abuse for instance:
- Older or disabled victims may be dependent on the abuser for care
  - Victims from black or ethnic minority groups, where the violence is perpetrated by extended family members or relate to forced marriage issues, may be more isolated due to religious and/or cultural pressures, language barriers, having no recourse to public funds or fear of bringing shame to their 'family honour'
  - Male victims who feel ashamed due to perceived stigma attached to being a man who lets a woman be violent towards him
  - Victims from same sex relationships who fear stigma and prejudice
  - Victims with other problems e.g. mental health or substance misuse issues, may fear that they will not be believed
  - Victims will want the violence to stop, but may want to save the relationship

### **Additional considerations where a parent is fleeing from domestic violence**

- 9.5.13 Victims are at most risk at the point of leaving, or having recently left the violent partner and may need support.
- 9.5.14 A parent and child/ren fleeing from domestic violence may require a significant level of support as they may be:
- Experiencing problems with housing, finance and employment
  - Isolated from usual family support / community networks – especially if moved / placed outside their home area
  - Struggling to provide / maintain stability
- 9.5.15 Women with children fleeing domestic violence may receive support from the housing department. Children's Social Care should be included in planning the course of action if relocation is necessary.

## INITIAL RESPONSE TO DOMESTIC VIOLENCE

- 9.5.16 Police are often the first point of contact and they (or any other agency that becomes aware of domestic violence) should undertake a risk assessment ('Separation, Pregnancy, Escalation, Cultural Awareness, Stalking and Sexual Assault' (SPECSS) model of risk assessment in the case of the Police), ensure the safety of the victim and:

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- Ascertain whether there are any children living in the household or if the victim is pregnant
- Make a preliminary determination of the degree of exposure of the children to the incidents of violence and its consequent impact
- If there is an immediate direct risk to a child, ensure immediate protective action is taken (see 6.6)
- Provide the victim with information on local support services and refuge details, taking into account any ethnic or cultural issues (i.e. National Helpline, local specialist agencies / help-lines, Woman's Aid, Victim Support – details available from local domestic violence forums)

## POLICE NOTIFICATION PROCEDURE

- 9.5.17 Where there are children under the age of eighteen years in the household, the Police officer attending a domestic incident must undertake a SPECSS risk assessment and complete the following tasks before the end of her/his tour of duty:
- Inform the parent / carer that details of the incident will be shared with partner agencies in accordance with these procedures
  - Complete a risk identification booklet providing full details of child/ren including ages, indicating in the record if and of what a parent / carer refuses to provide details
  - Submit the booklet to supervisory officer for authorisation and signature, which must then be forwarded to the relevant Police domestic violence unit (DVU)
  - Confirm that they have provided relevant information leaflets on local support services and refuge details (or provide an explanation if this has not been accomplished)
- 9.5.18 The Police should advise parents verbally that a record will be given to other agencies. However, the varied circumstances of Police attendance may mean that this does not always happen explicitly. Nevertheless, Police will still need to share this information (including outcome of the risk assessment) with other agencies as described below (see information sharing advice in module 2).
- 9.5.19 The DVU are responsible for evaluating the level of risk relating to the victim's perceived risk of serious harm or death, based on available information. Those completing the initial risk indicator section are not expected to have high levels of knowledge about domestic violence and its analysis.

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- 9.5.20 Regardless of where the domestic violence occurs, the Police DVU must notify the Police CAIU and Children's Social Care within five working days of every incident of domestic violence when there is known to be:
- A child resident, or regularly staying, in the household
  - A pregnant victim of domestic violence
  - The victim is a child her/him self
- 9.5.21 Regardless of where the domestic violence occurs the Police DVU must notify the NHS Trusts within forty eight hours of every incident of domestic violence where there is known to be:
- A child under the age of five years resident, or regularly staying, in the household
  - A pregnant victim of domestic violence
- 9.5.22 The notification provided by the DVU will be an e-mail of the 34d referral form (appendix B) and the level of risk to the victim (not the child/ren) identified by the Police. These must be sent to the nominated agency representative at a secure e-mail address.
- 9.5.23 Children's Social Care (Client Services) must within five working days, acknowledge receipt of the form.
- 9.5.24 Children's Social Care (Client Services) has the responsibility for identifying and forwarding the form to the relevant social worker. The designated nurse has the responsibility for identifying and forwarding the form to the relevant health visitor and/or midwife and GP who must provide feedback to the 'Domestic Violence Liaison Officer' within five working days.
- 9.5.25 Victim Support should be notified if the aggrieved person requests it.

### ALL AGENCIES RESPONSE TO RECOGNITION / NOTIFICATION OF DOMESTIC VIOLENCE

- 9.5.26 This procedure applies to all practitioners in LSCB agencies. Other organisations e.g. refuges should also be encouraged to adopt them.

#### Agency history

- 9.5.27 On notification / disclosure / suspicion of domestic violence in a family, all agencies must immediately consult existing records and consider what else is known of the family and any previous domestic incidents.
- 9.5.28 Those in receipt of Police notifications may contact the Police domestic violence officer if more information is required.

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### Information sharing

- 9.5.29 Multi-agency work and information sharing (in accordance with module 3) is crucial in safeguarding children in situations of domestic violence.
- 9.5.30 Information must be shared and appropriate referrals made if the practitioner considers this to be in the best interests of the child, even if this is initially without knowledge of the parties involved or contrary to their specific wishes (see [3.5.14](#) )

### Agency information sharing with Children's Social Care

- 9.5.31 Police share information of domestic violence incidents as described in Police Notification procedure (see [9.5.17- 9.5.25](#)).
- 9.5.32 When other agencies have information about domestic violence, it must be shared with Children's Social Care if:
- There has been a serious incident regardless of whether the child is present at the time e.g. injury to parent
  - An alleged victim is a child her/himself
  - A parent is fleeing domestic violence, leaving a child with the allegedly violent partner
  - A parent and child/ren are fleeing domestic violence (the victim may return home and/or alleged perpetrator may seek them out)
  - The alleged victim is pregnant
  - There is a child under the age of two in the household
  - There have been previous serious incidents
  - There is a history of aggressive violence or 'stalking' by the perpetrator (this may or may not include convictions)
  - There are / have been allegations of sexual assault or rape
  - There has been more than one minor domestic violence incident within the last twelve months
  - The child/ren have witnessed or been distressed through hearing incident/s of domestic violence (see also [3.5.14](#) )
- 9.5.33 Consideration must be given to sharing information if there are or have been:
- Parental difficulties e.g. mental health, substance misuse, parental learning disability
  - Previous child welfare concerns
  - Concerns about abuse of animals
  - Knowledge of any particular stressors in the family e.g. disability or health related, housing / immigration / legal / financial / social isolation
  - Separation / contact issues

## RESPONSE: CHILDREN'S SOCIAL CARE

9.5.34 Following consultation of agency history Children's Social Care must decide how to respond to each communication of domestic violence.

### Agency checks

9.5.35 Client Services duty manager may decide to treat the communication as 'information and advice' only if all the following apply:

- This is the first report of domestic violence in the last twelve months and
- The report concerns a minor incident, without injury and
- There are no other indicators of risk e.g. none of the circumstances in [9.5.32](#) apply and there are no high risk indicators in the Police assessment

9.5.36 Generally, further information from other agencies will be required before a decision can be made about the appropriate threshold of response.

9.5.37 In making the decision about seeking information prior to / after direct contact with the family, consideration should be given to the:

- Likely impact to the child and the adult victim, including the possibility of increasing the risk of domestic violence
- Need for an approach that takes full account of information available on home circumstances

### Direct contact

9.5.38 The Police should have already provided the victim with information leaflets (see [9.5.17](#)).

9.5.39 Careful consideration should be given to the purpose and method of contacting the family, particularly in relation to the wording of any letters sent out to the family.

9.5.40 Where the threshold criteria for a Children's Social Care Initial Assessment / s.47 enquiry are not met, consideration should be given to the use of universal services e.g. undertaking a common assessment / CAF, if this is thought to be less likely to exacerbate the situation.

### Initial Assessment / s.47 enquiries

9.5.41 A **minimum** response of an Initial Assessment must be undertaken for any serious incidents of domestic violence (e.g. where an injury has occurred) and where a child is living / regularly staying at the household.

## ADDITIONAL PROCEDURES

- 9.5.42 Initial Assessments should also be undertaken for lesser incidents where there are possible concerns about the welfare of the children e.g. the circumstances described in 9.5.33 and high risk on the Police assessment (but see 9.5.32)
- 9.5.43 More minor incidents should be considered individually, but no more than one incident within twelve months should be reported without the completion of at least an Initial Assessment.
- 9.5.44 Where the family refuse to co-operate with an Initial Assessment, consideration should be given to the justification for a s.47 enquiry.
- 9.5.45 Circumstances in which a s.47 enquiry should be undertaken include those when:
- A child has experienced significant harm during any domestic violence incident even if inadvertently injured
  - A child has witnessed another being seriously injured
  - The victim is pregnant or there is a child aged under two in the household
  - There has been an escalation in frequency and/or severity of incidents (reported or not)
  - The violence involved sexual assault or attempted strangulation or the use of weapons or threats to kill
- 9.5.46 If a **child** is known to be involved in a violent relationship, a s.47 enquiry should be initiated e.g. a child involved in a relationship with a violent girlfriend / boyfriend.
- 9.5.47 Whenever an Initial Assessment or s.47 enquiry is undertaken there must be liaison with all agencies involved with the family and the child/ren must be seen.

### Assessment process

- 9.5.48 Opportunities should be provided for both partners to be interviewed separately, and in a safe setting.
- 9.5.49 Many victims of domestic violence feel unable to disclose its existence or severity. The following issues should be discussed with the alleged victim as part of any assessment:
- Severity, frequency and history of any violence, threats etc
  - Circumstances of the violence and if compounded by drugs / alcohol
  - Extent and nature of the children's experience of the violence
  - Perception of risk to the child/ren
  - Threats used – consider all household members

## ADDITIONAL PROCEDURES

- Available options – immediate and in the long term
  - Factors that prevent the victim taking action to protect self and children
  - Whether it is possible to share victim's perceptions with alleged perpetrator
- 9.5.50 The alleged victim of violence should be advised of the availability of legal advice and the options available through the Protection from Harassment Act 1997 and the Family Law Act 1996 Part IV.
- 9.5.51 The interview with the alleged perpetrator of the violence should be planned carefully between the worker and their line manager. Care must be taken not to disclose addresses or make unsafe contact arrangements.
- 9.5.52 If there is an acknowledgement of violence, the interview should clarify the points above. Where there is no acknowledgement of violence and it is not possible to share the victim's account, there should be general discussions about the children's welfare.
- 9.5.53 The children should be interviewed (if of sufficient age and understanding) and their experiences explored. It is important to consider the possibility that a child may have experienced direct abuse her/himself and /or may be inhibited from disclosing concerns due to fear of (further) domestic violence or (further) abuse.

### Intervention

- 9.5.54 If a child protection conference is held, consideration should be given to any need to exclude the violent partner for part or all of the meeting (see 7.6).
- 9.5.55 The local authority may pursue legal options of:
- Relocation of alleged perpetrators of abuse
  - Injunctions attached to a s.8 Children Act 1989 Prohibited Steps Order
  - Exclusion conditions attached to an Emergency Protection and interim Care Order
  - An injunction under the Housing Act 1996 (chapter III of Part V) to restrain anti-social behaviour with power of arrest attached, where violence has occurred or is threatened
- 9.5.56 Women with children fleeing domestic violence may receive support from the housing department. Children's Social Care should be included in planning the course of action if relocation is necessary.

## 9.6 ENQUIRIES INVOLVING DIPLOMATS' FAMILIES

### LEGAL POSITION

- 9.6.1 Where there is concern that a child who is a member of a diplomat's family is at risk of abuse caution must be exercised in taking protective measures. Diplomats and members of their household have immunity from civil, criminal and administrative jurisdiction. They cannot be detained, arrested nor have their homes entered without consent.
- 9.6.2 The distinction is drawn between the head of the diplomatic mission, members of the technical and administrative staff and general members of the mission, and by association each category's household. The rank of the person in question must therefore be established as a priority.
- 9.6.3 Different categories of staff of the mission are entitled to different forms of immunity.
- 9.6.4 The head of the mission is entitled to full criminal and civil immunity. Technical and administrative staff are entitled to full criminal immunity and full civil immunity for acts within the course of their duties - e.g. a chauffeur is subject to the Children Act 1989 for acts which fall outside of the course of her/his duties.
- 9.6.5 General members - e.g. members of the domestic service staff have immunity only for acts in the course of their duties in respect of both criminal and civil matters.
- 9.6.6 Should abuse be suspected in a family cited above, it is possible to proceed (cautiously) in the usual manner.
- 9.6.7 Certain immunity applies to the residence of the diplomat or to categories of diplomatic employees. The residence of diplomats and certain employees is inviolable and legal advice must be sought before attempting to force the removal of the child from that location. In most instances, it will be advisable to consider removing the child from school or another place outside of her/his residence.
- 9.6.8 The inviolability of the diplomat's residence does not preclude reliance on evidence of abuse thought to have taken place within the residence.
- 9.6.9 Careful consideration must also be given to the possibility of being able to enforce any order should the child return to the diplomat's residence and refuse to surrender. Enforcement may provoke difficulties in itself, but does not deprive the local authority of the power or duty to take action.

## ADDITIONAL PROCEDURES

### ACTION BY CHILDREN'S SOCIAL CARE & POLICE

- 9.6.10 It is important in all these case to establish whether diplomatic immunity may be claimed and to what extent. The Foreign and Commonwealth Office is prepared to give advice on this point and the Children's Social Care team manager should contact the 'immunities section of the protocol department' on 020 7210 6383.
- 9.6.11 Out of office hours, the Police may be asked to ascertain the status of an individual by consulting the central index of privileged person maintained by the Diplomatic Protection Group.
- 9.6.12 The Head of Child Protection must be notified of all enquiries which may involve diplomatic families and s/he in consultation with the local authority's legal department is responsible for co-ordinating any necessary action via the Foreign Office.
- 9.6.13 Children from these diplomatic backgrounds should be subject to ordinary processes including information transfer (preferably at a conference) should the family move to a new area.

## 9.7 FABRICATED OR INDUCED ILLNESS (FII)

### INTRODUCTION

- 9.7.1 This section outlines the procedures to follow when professionals are concerned that the health or development of a child may be significantly impaired by the actions of a carer having fabricated or induced illness.
- 9.7.2 Further guidance is provided in DH 2002 document *Safeguarding Children in Whom Illness is Fabricated or Induced and Hertfordshire Fabricated or Induced Illness Guidance, November 2003*.
- 9.7.3 The Royal College of Paediatricians and Child Health 2002 *Fabricated or Induced Illness by Carers* provides further guidance for medical clinicians  
([http://www.rcpch.ac.uk/publications/recent\\_publications/FII.pdf](http://www.rcpch.ac.uk/publications/recent_publications/FII.pdf) )

### DEFINITION

- 9.7.4 Fabricated or induced illness (FII) in a child is a condition whereby a child suffers harm through the deliberate action of her/his main carer and which is duplicitously attributed by the adult to another cause.

## ADDITIONAL PROCEDURES

9.7.5 The DH describe three main (and not mutually exclusive ways) of the carer fabricating or inducing illness in a child:

- **Fabrication** of signs and symptoms, including fabrication of past medical history
- **Fabrication** of signs and symptoms and **falsification** of documents / specimens e.g. hospital charts, records, letters, specimens of bodily fluids
- **Induction** of illness by a variety of means

9.7.6 FII is characterised by the following features:

- Deliberately inducing symptoms in children by administering medication or other substances or by means of intentional suffocation
- Interfering with treatments by overdosing, not administering them or interfering with medical equipment such as infusion lines
- Claiming the child has symptoms, which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits. These claims result in unnecessary investigations and treatments, which may cause secondary physical problems
- Exaggerating symptoms, causing professionals to undertake investigations and treatments, which may be invasive, are unnecessary and therefore are harmful, usually uncomfortable and possibly dangerous
- Obtaining specialist treatments or equipment for children who do not require them
- Alleging psychological illness in a child

## SIGNIFICANT HARM TO THE CHILD

9.7.7 Harm to the child may be caused through unnecessary or invasive medical treatment, which may be painful, harmful and possibly dangerous, based on symptoms that are falsely described or deliberately manufactured by the carer, and lack independent corroboration.

9.7.8 The child may additionally suffer emotional harm through limitations placed on her/his development and social interaction due to her/his perceived illness e.g. overprotection, limitation of exploration and learning, prevention from participation in normal social interaction.

## RECOGNITION OF EMERGING CONCERNS

9.7.9 Doctors / paediatricians may be concerned at the possibility of a child suffering significant harm as a result of having illness fabricated or induced by her/his carer. These concerns may arise when:

## ADDITIONAL PROCEDURES

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering / correlated with any disease
  - Physical examination and results of investigations do not explain reported symptoms and signs
  - There is an inexplicably poor response to prescribed medication and treatment
  - New symptoms are reported on resolution of previous ones
  - Reported symptoms and found signs are not observed to commence, in the absence of the carer
  - Over time the child repeatedly presents with a range of symptoms
  - The child's normal, daily life activities are being curtailed beyond that which might be expected from any known medical disorder from which the child is known to suffer
- 9.7.10 There may be a number of explanations for these circumstances and each requires careful consideration and review.
- 9.7.11 Concerns may be raised by other professionals e.g. nurses, teachers or social workers who are working with the child and who may notice unusual features such as:
- Discrepancies between reported and observed medical conditions, such as the incidence of fits
  - Unauthorised attempts to administer medication
  - Records being altered
- 9.7.12 Professionals working with the child's parents / carers may also note relevant concerns e.g. mental health professionals may identify a child being drawn into the parents illness.
- 9.7.13 Features that may be associated with this form of abuse, but none of which are themselves indicative, are:
- Early commencement of child's medical, especially hospital, treatment
  - Attendance at various hospitals, in different geographical areas
  - Development of feeding / eating disorders, as a result of unpleasant feeding interactions
  - The child developing abnormal attitudes to their own health
  - History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
  - Past history in the carer of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault
  - Carers may be over involved in participating in medical tests, taking temperatures and measuring bodily fluids

## ADDITIONAL PROCEDURES

- Carer/s are observed to be intensely involved with their children, never taking a much needed break nor allowing anyone else to undertake their child's care.
  - Carer/s may appear unusually concerned about the results of investigations which may indicate physical illness in the child
- 9.7.14 Generally, some indicators of abuse mentioned in module 3 (often in the context of wider parenting difficulties), may (or may not) be associated with this form of abuse, such as:
- Non organic failure to thrive
  - Speech, language or motor developmental delays
  - Dislike of close physical contact
  - Attachment disorders
  - Low self esteem
  - Poor quality or no relationships with peers because social interactions are restricted
  - Poor attendance at school and under-achievement
  - Child's carers may have history of abuse and/or psychiatric illness

## RESPONSE

- 9.7.15 All professionals should routinely keep records relating to the child. Whenever unusual features are noted as described above it is extremely important that detailed records are maintained of events, reported illnesses, parent / carer explanations of illness and absences from school and child's symptoms when carer present and in her/his absence.
- 9.7.16 Concerns about a child's health should be discussed as early as possible with the appropriate health professional responsible for the child's health e.g. GP, paediatrician.
- 9.7.17 Where a child is undergoing significant ongoing medical treatment, liaison must always take place with the GP to assist in the confirmation of diagnosis and subsequent treatment.
- 9.7.18 If any professional considers their concerns are not responded to appropriately, the concerns should be discussed with the designated doctor or nurse and /or the professional's own lead, designated or named professional.
- 9.7.19 If any concerns relate to a member of staff the procedures in module 10 Allegations Against Those Working with Children must be followed.

## ADDITIONAL PROCEDURES

### Medical evaluation

- 9.7.20 The signs and symptoms require careful medical evaluation for a range of possible diagnoses.
- 9.7.21 All tests and their results should be fully and accurately recorded. It is important that the child's record is not altered in any way, e.g. through tampering with test results.
- 9.7.22 The name of the person reporting any observations should be legibly recorded and dated.
- 9.7.23 **When suspicion of FII first arises, the paediatrician has a duty to consult widely in an attempt to confirm or refute the suspicions.** [Recommendation 7 of *Fabricated or Induced Illness by Carers* The Royal College of Paediatricians and Child Health 2002].
- 9.7.24 A chronology of health involvement, including access to all health facilities, should be prepared so as to provide comprehensive information.
- 9.7.25 Parents should be kept informed of further assessments / investigations / tests required and of the findings. Normally, the doctor would tell the parent/s that s/he has not found the explanation and record the parental response.
- 9.7.26 Concerns about the reasons for the child's signs and symptoms should not be shared with parents, if this information is likely to jeopardise the child's safety.

### Referral to Children's Social Care and / or CAIU

- 9.7.27 The referral to Children's Social Care may follow a medical evaluation or be the result of concern by professionals or members of the public.
- 9.7.28 When a professional working with children suspects a possible explanation for signs and symptoms is FII, s/he should make a referral to Children's Social Care. This will usually follow a consultation with the professional's relevant designated (or alternative professional with lead responsibility for child protection) doctor, clinician, nurse or teacher.
- 9.7.29 The Royal College of Paediatrics and Child Health 2002 *Fabricated or Induced Illness by Carers* recommends 'When there are persisting concerns there should be a wider assessment by the social services department. **The criterion for referral is that the paediatrician has continuing concerns about the child's welfare and not that fabrication or illness induction or harm has been proved.**'

## ADDITIONAL PROCEDURES

- 9.7.30 This guidance makes it clear that paediatricians should undertake consultation with other agencies, as part of the process of confirming (or disproving) the possibility of FII.
- 9.7.31 Whilst professionals should in general, discuss any concerns with the family and, where possible, seek agreement to making referrals to Children's Social Care, this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm.
- 9.7.32 The Police CAIU must be informed of any referral where FII is suspected as this may also involve the commission of a crime.
- 9.7.33 If intervention is required immediately due to concern about immediate harm to the child e.g. observed that medication / feeds tampered with in hospital, medical staff should call the Police using the '999' service.

### Initial consideration of referral

- 9.7.34 As with all other referrals, Children's Social Care should decide, within one working day, the response required.
- 9.7.35 The decision must be taken in consultation with the consultant paediatrician responsible for the child's health care and the CAIU.
- 9.7.36 This decision making process must agree the action to be taken, by whom and within what time frame.
- 9.7.37 All decisions about what information is shared with parents should be agreed between the CAIU, Children's Social Care, the consultant paediatrician and the referring professional, bearing in mind the safety of the child and the conduct of any Police investigations.
- 9.7.38 Possible outcomes of referrals are the same as any other referral.
- 9.7.39 If emergency action is required e.g. if a child's life is in danger through toxic substances being introduced into the blood stream, an immediate strategy discussion should take place, where possible, between Children's Social Care, CAIU, health and other agencies as appropriate. However this should not delay the use of immediate protection if required (see 6.6).

### Initial Assessment

- 9.7.40 An Initial Assessment should be completed, as with all referrals (see 5.5) following paragraphs 3.9 - 3.10 of the DH guidance to the Assessment Framework (details in bibliography).
- 9.7.41 This should be undertaken in collaboration with the consultant paediatrician responsible for the child's health care.

## ADDITIONAL PROCEDURES

- 9.7.42 If a second medical opinion has not previously been obtained The Royal College of Paediatricians and Child Health 2002 *Fabricated or Induced Illness by Carers* (p.35 ) suggests that this is the point when it is sought.
- 9.7.43 The outcomes of the Initial Assessment are as described in 5.5 for other referrals. The decision should be made in consultation with the paediatrician consultant and CAIU, with agreement reached regarding what the parents should be told. 'Concerns should not be raised with a parent if it is judged that this action will jeopardise the child's safety.' (*Safeguarding Children in Whom Illness is Fabricated or Induced* paragraph 3.18)

### Strategy discussion

- 9.7.44 If there is reasonable cause to suspect the child is suffering, or likely to suffer significant harm, Children's Social Care should convene and chair a strategy discussion involving all the key professionals. A meeting is advisable when considering this complex form of abuse.
- 9.7.45 A strategy meeting must be chaired by a Children's Service Manager, who may choose to invite a Principal Officer or the Head of Child Protection.
- 9.7.46 This meeting requires the involvement of key senior professionals responsible for the child's welfare. At a minimum this must include Children's Social Care, CAIU and the paediatric consultant responsible for the child's health. Additionally the following should be invited as appropriate:
- A senior ward nurse if the child is an in-patient,
  - A medical professional with expertise in the relevant branch of medicine
  - GP, health visitor
  - Staff from education settings
  - Child litigation unit solicitor
- 9.7.47 When it is decided that there are grounds to initiate a s.47 enquiry decisions should be made about how the enquiry, as part of the Core Assessment, will be carried out. The decisions usually taken at a strategy discussion (see 6.7) will apply here and additional factors to address are:
- What further information is required about the child and family and how it should be obtained and recorded (including school attendance records, previous addresses and previous professional involvement, professionals knowledge of other concerns)
  - Whether the child requires constant professional observation, and if so, whether the carer should be present

## ADDITIONAL PROCEDURES

- Does the child need immediate separation from the parent for reasons of safety?
- The designation of a medical clinician to oversee and co-ordinate medical treatment: to act as main point of contact with the family, control the number of specialists and hospital staff the child may be seeing, plan further paediatric assessment, consult with medical colleagues (including those who have treated the child before)
- Arrangements for the medical records of all family members, including parent's and children who may have died or no longer live with the family, to be collated by the consultant paediatrician or other suitable medical clinician
- The nature and timing of any Police investigations, including analysis of samples and covert surveillance (this will be Police led and co-ordinated)
- Careful laboratory documentation, where relevant
- The need for extreme care over confidentiality, including whether it is necessary for supplementary records to be kept in a secure place in order to safeguard the child and the manner in which they should be kept
- The need for expert consultation
- Any particular factors, such as the child and family's race, ethnicity, language and special needs which should be taken into account
- The needs of siblings and other children with whom the alleged abuser has contact
- The needs of parents or carers (and how they should be informed of concerns)
- Obtaining legal advice over evaluation of the available information (if legal adviser not present at meeting)
- Timescales for any further strategy discussions, and if previous treating physicians should be invited to a meeting

9.7.48 Investigating this specific circumstance is complex and disturbing for practitioners and one worker should not undertake the enquiry in isolation. The strategy discussion should recognise the need to ensure multi-agency co-ordinated working and good supervision.

9.7.49 If at any point there is medical evidence that the child's symptoms are being fabricated or induced, action may be required to ensure the child's life is not put at risk (see Immediate Protection 6.6).

9.7.50 There will usually be at least one further strategy meeting to evaluate the information collected and agree the next steps: 'It may be necessary to have more than one strategy meeting. This is likely where the child's circumstances are complex and a number of discussions are required to consider whether and, if relevant, when to initiate s.47 enquiries' (*Safeguarding Children in Whom Illness is Fabricated or Induced* para. 3.28).

## ADDITIONAL PROCEDURES

### The enquiry

- 9.7.51 The carer may present as very plausible and well informed as to the nature of the child's medical problems.
- 9.7.52 It is important to keep a focus on the impact of the carer's behaviour on the child when assessing levels of risk.
- 9.7.53 Children under the age of 5, especially pre-verbal children and children with an existing bone fide illness, disability and/or communication difficulties are at greatest risk because of their inherent vulnerability.
- 9.7.54 Early confrontation with the suspected abuser should generally be avoided until all information is available, thoroughly documented and provisions made for the protection of the children. This action should be planned with CAIU (see [9.7.57](#) onwards below).
- 9.7.55 Before placing children with members of either extended family, a thorough assessment of them should have taken place. FI may (or may not) be a feature of the family behaviour in previous generations. Any alternative carer should demonstrate an ability to believe that the suspected abuser may have posed a risk to the child.
- 9.7.56 A psychiatrist should be involved at the point at which there is moderate to high suspicion that a parent has been inducing symptoms or a court has made a finding of fact that such behaviour has occurred.

### Police investigation

- 9.7.57 Any evidence gathered by Police should be available to other relevant professionals, to inform discussions and decisions about the child's welfare and contribute to the s.47 enquiry and Core Assessment, unless this would be likely to prejudice criminal proceedings.
- 9.7.58 It is important that suspects' rights are protected by adherence to the Police and Criminal Evidence Act 1984, which would normally rule out any agency other than the Police confronting any suspect persons.
- 9.7.59 Covert video surveillance is a legitimate investigative tool, but its use should only be considered when a multi-agency strategy discussion has agreed there is no other available way of obtaining information that will explain the child's signs and symptoms.
- 9.7.60 Police officers are able to obtain good practice advice from the National Crime Faculty on the use of this method of investigation.

## ADDITIONAL PROCEDURES

- 9.7.61 The primary aim of covert video surveillance is to identify if a child is having illness induced. Obtaining criminal evidence is of secondary importance.
- 9.7.62 Once this decision has been made, the Police will be responsible for applying for the appropriate authority under the Regulation of Investigatory Powers Act 2000. If that authority is granted, the Police have sole responsibility for implementing and undertaking any such surveillance.
- 9.7.63 The safety and health of the child is the over-riding factor in the use of covert video surveillance, and the medical consultant responsible for the child's care should ensure that the necessary medical and nursing staff support the Police operation.
- 9.7.64 All non-Police staff involved will receive appropriate training from the Police, and understand the need for strict secrecy during the operation.

### Outcome of enquiries

- 9.7.65 As with all s.47 enquiries, the outcome may be that concerns are not substantiated e.g. tests may identify a medical condition, which explains the signs and symptoms.
- 9.7.66 It may be that no protective action is required, but the family should be provided with the opportunity to discuss what further help it may require and consideration should be given to the use of a child in need plan.
- 9.7.67 Concerns may be substantiated, but an assessment made that the child is not judged to be at continuing risk of harm.
- 9.7.68 Where concerns are substantiated and the child judged to be suffering or at risk of suffering significant harm, a conference must be convened. All evidence should be thoroughly documented by this stage and the protection plan for the child already in place.

### Initial child protection conference

- 9.7.69 The conference should be held within fifteen working days from the last strategy discussion.
- 9.7.70 Attendance at this conference should be as for other initial conferences, with the additional experts invited as appropriate:
- Professional with expertise in working with children where FII is suspected
  - Paediatrician with expertise in the branch of paediatric medicine concerned, able to present the medical findings

## ADDITIONAL PROCEDURES

- 9.7.71 The Royal College of Paediatricians and Child Health 2002 Fabricated or Induced Illness by Carers state 'that it is absolutely essential that the consultant paediatrician and GP attend ...and provide a chronology and a full report.'
- 9.7.72 Subsequent management of the case is the same as described in module 7 (and if relevant 8).

## 9.8 FEMALE GENITAL MUTILATION

### Definition

- 9.8.1 Female genital mutilation (FGM) is a collective term for procedures which include the removal of part / all external female genitalia for cultural or other non-therapeutic reasons.
- 9.8.2 The practice is not required by any major religion and is medically unnecessary, painful and has serious health consequences at the time it is carried out and in later life.
- 9.8.3 The procedure is typically performed on girls aged between 4 and 13, but is also performed on new born infants and on young women before marriage / pregnancy. A number of girls die as a direct result of the procedure, from blood loss or infection.
- 9.8.4 Girls may be circumcised or genitally mutilated illegally by doctors or traditional health workers in the UK, or sent abroad for the operation.

### Law

- 9.8.5 Female circumcision, excision or infibulation (female genital mutilation) is illegal in this country by the Female Genital Mutilation Act 2003, except on specific physical and mental health grounds ( see [www.homeoffice.gov.uk](http://www.homeoffice.gov.uk) .
- 9.8.6 It is an offence to:
- Undertake the operation (except in specific physical or mental health grounds)
  - Assist a girl to mutilate her own genitalia
  - Assist a non-UK person to undertake FGM of a UK national outside the UK (except in specific physical or mental health grounds)
  - Assist a UK national or permanent UK resident to undertake FGM of a UK national outside the UK (except in specific physical or mental health grounds)

### RECOGNITION

- 9.8.7 Any medical provision for a pregnant woman who has herself been the subject of female genital mutilation provides the opportunity for recognition of risk and preventative work with parents.
- 9.8.8 A child may be considered to be at risk if it is known older girls in the family have been subject to the procedure. Pre-pubescent girls aged seven to ten are the main subjects, though the practice has been reported amongst babies.
- 9.8.9 Suspicions may arise if a family is known to belong to a community in which FGM is practised and is making preparations for the child to take a holiday, arranging vaccinations or planning school absence and the child may refer to a 'special procedure' taking place.
- 9.8.10 Indications that FGM may have already occurred include:
- Prolonged school absence with behaviour change on return
  - Bladder and menstrual problems
  - Reluctance to receive medical attention or participate in sport

### RESPONSE

- 9.8.11 Any suspicion of **intended or actual** FGM must be referred to Children's Social Care, in accordance with child protection procedures in modules [3](#) and [5](#).
- 9.8.12 Children's Social Care, must inform the Police CAIU at the earliest opportunity and convene a strategy meeting if:
- There is suspicion that a girl or young woman, under the age of eighteen, is at risk of undergoing this procedure
  - It is believed that a girl or young woman is at risk of being sent abroad for that purpose or
  - There are indications that a girl or young woman has suffered mutilation or circumcision
- 9.8.13 A Children's Service Manager should chair the strategy meeting. Health providers or voluntary organisations with specific expertise should be invited. A legal advisor should be invited or consulted about protective options prior to the meeting.
- 9.8.14 In planning any intervention it is important to consider the significance of cultural factors. FGM is generally performed because of the significance it has in terms of cultural identity and any intervention is more likely to be successful if it involves workers from, or with a detailed knowledge of, the community concerned.

## ADDITIONAL PROCEDURES

- 9.8.15 Under the Children Act 1989, possible legal proceedings could include a Prohibited Steps Order (s. 8) with or without a Supervision Order (s.35). Removal from home should be considered as a last resort.
- 9.8.16 If the child has already suffered female genital mutilation the meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services.
- 9.8.17 Female genital mutilation is a one-off event of physical abuse (albeit one that may have grave permanent sexual, physical, and emotional consequences), not an act of repeated abuse and organisational responses need to recognise this.
- 9.8.18 A 2<sup>nd</sup> strategy meeting should take place within 10 working days of the first meeting, with the same chair. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary.
- 9.8.19 A girl who has already been genitally mutilated should not normally be the subject of a conference or the subject of a protection plan unless additional concerns exist, though she should be offered counselling and medical help. Consideration must however be given to any other female siblings at risk.

### Child protection conference

- 9.8.20 A girl believed to be in danger of FGM may be made the subject of a protection plan, under the category of risk of physical abuse, if the criteria (see 3.3) are applicable, including the need for the future protection of the child.
- 9.8.21 The main emphasis of work in cases of actual or threatened FGM should be through education and persuasion. This approach will be reflected in the child protection plan.

## PREVENTION

- 9.8.22 Agencies should work together to promote a better understanding of the damaging consequences to health (physical and psychological) of FGM.
- 9.8.23 Wherever possible the aim must be to work in partnership with parents and families to protect children through parents' awareness of the harm caused to the child.

## FURTHER ADVICE

9.8.24 Useful contacts are:

- Foundation for Women's Health, Research & Development, 6<sup>th</sup> Floor, 50 Eastbourne Terrace, London W2 6LX, Tel. 0207 725 2606 [www.forwarduk.org.uk](http://www.forwarduk.org.uk)
- The African Well Woman Clinic at Central Middlesex Hospital, Acton Lane, Park Royal, NW10 7NS

## 9.9 FORCED MARRIAGES

### DEFINITION

9.9.1 A 'forced' marriage (as distinct from a consensual 'arranged' marriage) is defined as one conducted without the valid consent of at least one of the parties and where duress is a factor.

9.9.2 Duress cannot be justified on religious or cultural grounds.

9.9.3 Forced marriages of children may involve non-consensual and/or underage sex, emotional and possibly physical abuse and should be regarded as a child protection issue and referred to Children's Social Care.

9.9.4 Although there is no specific criminal offence of a forced marriage, the forced marriages of children (and vulnerable adults) may involve one or more criminal offences e.g. common assault, cruelty to persons under 16, child abduction, rape, kidnapping, false imprisonment and even murder.

9.9.5 Forced marriage is primarily, but not exclusively, an issue of violence against girls and young women.

9.9.6 Whilst the majority of cases encountered in the UK involve South Asian families, partly reflecting the composition of the UK population, there have been cases involving families from East Asia, the Middle East, Europe and Africa.

9.9.7 Some forced marriages take place in the UK with no overseas element, whilst others involve a partner coming from overseas or a British citizen being sent abroad.

## RECOGNITION

- 9.9.8 Victims of existing or prospective forced marriages may be fearful of discussing their worries with friends and teachers, but may come to the attention of professionals for various behaviours or circumstances consistent with distress. These may include:
- A family history of siblings being forced to marry or to marry early
  - A sibling who suddenly disappeared or went abroad
  - Frequent authorised absences or truancy from school / lessons
  - Social isolation
  - A sudden decline in education performance, aspirations or motivation
  - Unreasonable restrictions on the child's liberty e.g. accompanied to / from school, not allowed to attend extra-curricular activities
  - Depression, self harming behaviour, eating disorders
  - Lethargy and inability to concentrate
  - Physical and domestic abuse
  - Running away from home
  - Reports of having left the country suddenly or being on an extended family holiday

### Response: all agencies

- 9.9.9 Staff should not make assumptions that a child is at risk and try to establish the full facts from the child at the earliest opportunity.
- 9.9.10 The child must be provided with the opportunity to speak alone in a private place. S/he may face significant harm if her/his family learn s/he has sought help or advice. **Mediation should not be attempted.**
- 9.9.11 The needs of victims of forced marriage vary. They may need help to avoid a threatened forced marriage or dealing with the consequences of a forced marriage that has already taken place.
- 9.9.12 Staff should seek consultation and advice from the designated / named professional. The Forced Marriage Unit should also be consulted (see [9.9.31](#) and contact details in appendix 1).
- 9.9.13 When there is information of an existing or prospective forced marriage of a child aged less than 18 years, child protection issues should be addressed by referral to Children's Social Care, **without prior discussion with the family or community.**
- 9.9.14 There should be a clear record of decisions made, including any decision not to consult or **not** to refer to Children's Social Care.

## ADDITIONAL PROCEDURES

### RESPONSE: CHILDREN'S SOCIAL CARE & CAIU

- 9.9.15 All referrals involving suspected forced marriage (actual or prospective) can involve complex and sensitive issues and social workers should inform the Children's Services Manager.
- 9.9.16 Police should be involved if a criminal offence has been committed.
- 9.9.17 Information to obtain in these cases includes:
- Details of referrer and relationship with child
  - Details of individual child under threat (including nationality, date of birth, passport details, school and employment details)
  - Full details of the allegation
  - Name and address of those with parental responsibility
  - Background family information and any history of forced marriage
- 9.9.18 In **all** cases efforts should be made to see the child immediately, on their own, in a secure and private place, even if the child is with others or the Police have been called to the home.
- 9.9.19 Information to be obtained in discussion with the child includes:
- List of any friends and family to be trusted
  - Possible code to ensure you are communicating with the right person in future (e.g. in telephone calls)
  - Background details of family including experiences of other family members of forced marriage, abuse or domestic violence
  - Nature and level of risk (e.g. existence of secret boyfriend / girlfriend, pregnancy, already secretly married)
  - Details of any perceived threats including potential spouses name, date of any proposed wedding, name of potential spouse's father (if known)
  - Possibility of obtaining a recent photograph and other identifying documents – if s/he is going abroad a photocopy of the passport, passport number and date of issue
  - School and any employment details
  - Involvement of other agencies
  - Document any distinguishing marks
- 9.9.20 The child should be reassured of confidentiality and allegations must not be shared with the child's family, friends or influential people within the community without the express consent of the child (and even then with due consideration of the implications to her / his safety).
- 9.9.21 The social worker and / or Police officer should not attempt to act as a mediator with the family.

## ADDITIONAL PROCEDURES

9.9.22 Government advice for Police and Children's Social Care includes:

- 'Do not treat an allegation of a prospective or actual forced marriage as a domestic issue and send the child back to the family home as part of routine s.47 enquiries
- Do not contact the family in advance of enquiries by phone or letter
- Do not allow unsupervised contact
- Provide the child, wherever possible, with the choice of race and gender of social worker and / or Police officer
- Inform the child of her/his right to seek legal advice and representation
- Liaise with the legal department
- Consult the Forced Marriage Unit (FMU), which provides confidential information and assistance to potential victims and concerned professionals (contact details in appendix 1)
- Create a restricted entry in the Police force intelligence system
- Inform child of her/his right to seek legal advice / representation
- Check Police and Children's Social Care records for past referrals of family members
- Record any injuries and arrange any required medical examination (Police)
- Provide personal safety advice (Police)
- Identify potential criminal offences, secure evidence and submit a crime report, if applicable (Police)
- Provide advice on service to be expected, contact details and other sources of help e.g. forced marriage unit, advocacy service and try to obtain agreement for referrals to local / national support groups'

9.9.23 If the individual is going overseas and there is concern that s/he may be forced into a marriage the following information is required:

- Photocopy of the individual's passport (s/he should also keep details of the passport number, place and date of issue)
- Father's name
- Any addresses where s/he may be staying overseas and of extended family in UK and overseas
- Potential spouses name, her /his father's name and date of proposed wedding (if known)
- Information that only the individual would be aware of (may assist in case another person is produced pretending to be the individual)
- Safe means of contact e.g. a mobile phone that will work overseas and details of a third party with whom to maintain contact
- Estimated return date when s/he should be asked to contact Police without fail (and her/his written statement requesting Police, Children's Social Care or a third party to act if s/he does not)

## ADDITIONAL PROCEDURES

### Intervention

- 9.9.24 If the child does not want Children's Social Care to intervene, the social worker will have to consider whether the child's safety (or that of others) requires that further action be taken.
- 9.9.25 Where there are concerns for an individual under 18 (or for their children) a strategy discussion / meeting with the Police and other relevant agencies must be initiated to decide whether the child is suffering, or at risk of suffering significant harm and if a s.47 enquiry should be initiated (or continued if already commenced).
- 9.9.26 The Head of Child Protection or nominated representative should be involved in strategy discussions / meetings.
- 9.9.27 If there is an overseas dimension Children's Social Care and Police should liaise closely with the Community Liaison Officer at the Forced Marriage Unit (0207 008 8706 / 0230 / 0135).
- 9.9.28 Where a child spouse has come to the UK from overseas without family and states s/he was forced into marriage and does not want to remain with the spouse, Children's Social Care should consider the child in the same manner as an unaccompanied asylum-seeking minor, and accommodate her/him (unless a needs assessment reveals a more appropriate alternative response).
- 9.9.29 If the risk of forced marriage is immediate, it may be necessary to take emergency action to protect the child (see 6.6).

### Further guidance & advice

- 9.9.30 Professionals working in this field should be familiar with:
- *Dealing With Cases of Forced Marriage: Guidance for Police Officers* Home Office 2005  
([www.acpo.Police.uk/asp/policies/Data/Interactive\\_Forced\\_Marriage\\_2005.pdf](http://www.acpo.Police.uk/asp/policies/Data/Interactive_Forced_Marriage_2005.pdf))
  - *Young people & vulnerable adults facing forced marriage: practise guidance for social workers*, Foreign & Commonwealth Office, March 2004 ([www.adss.org.uk/publications/guidance/marriage.pdf](http://www.adss.org.uk/publications/guidance/marriage.pdf))
  - *Young people & vulnerable adults facing forced marriage: Guidance for Education Professionals*, Foreign & Commonwealth Office, January 2005  
[publications.teachernet.gov.uk/eOrderingDownload/FCO%2075263.pdf](http://publications.teachernet.gov.uk/eOrderingDownload/FCO%2075263.pdf)
- 9.9.31 The Forced Marriage Unit (FMU) is Government's central unit dealing with forced marriage casework, policy and projects. The FMU provides confidential information and assistance to potential victims and concerned professionals (contact details in appendix 1).

## ADDITIONAL PROCEDURES

- 9.9.32 FMU staff can offer advice and assistance to individuals who:
- Fear they will be forced into a marriage (in UK or overseas)
  - Fear for a friend or relative who may be forced into a marriage (in the UK or overseas)
  - Have been forced into a marriage and do not want to support their spouse's visa application

## 9.10 HISTORICAL ABUSE ALLEGATIONS

### SIGNIFICANCE

- 9.10.1 Organisational responses to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to current abuse because:
- There is a significant likelihood that a person who abused a child/ren in the past will have continued and may still be doing so
  - Criminal prosecution remains a possibility if sufficient evidence can be carefully collated
- 9.10.2 Police must be informed about allegations of crime at the earliest opportunity. Whether Police become involved in an investigation will depend of a number of factors including victim's wishes and the public interest.

### RESPONSE

- 9.10.3 As soon as it is apparent an adult is revealing childhood abuse, the member of staff must avoid further questioning, record what is said and the responses given. A chronology should be undertaken and all records dated and the authorship made clear by a legible signature or name.
- 9.10.4 If possible, staff should establish if the adult is aware of the alleged perpetrator's recent or current whereabouts and contact with children.
- 9.10.5 An adult reporting her/his own experience of having been abused as a child should be asked whether s/he wants a Police investigation and must be reassured that Police CAIU are able and willing to undertake such work even for those adults who are vulnerable as a result of mental health or learning disabilities.
- 9.10.6 Consideration must be given to the therapeutic needs of the adult and reassurance given that, even without her/his direct involvement all reasonable efforts will be made to look into what s/he has reported.

## ADDITIONAL PROCEDURES

- 9.10.7 The social worker (Client Services) should inform the Police and establish if there is any knowledge regarding the alleged perpetrator's current contact with children.
- 9.10.8 A s.47 enquiry should be initiated if the alleged perpetrator is known currently to be caring for, or has access to children (and may require making the necessary referral to the area where the alleged perpetrator is now known to live). See also organised and complex abuse procedures [9.16](#)

## 9.11 HOSPITAL APPOINTMENTS, A & E ATTENDANCE & DISCHARGE PROCEDURES

### SCOPE

- 9.11.1 These procedures apply if:
- Child protection concerns are raised when a child is presented at an A & E department
  - Child protection concerns are raised about a child admitted to hospital
  - For a maternity unit and midwifery service, if there has been a pre-birth assessment or subsequent child protection concerns
  - A child is to be discharged to parents / carers with learning disabilities, substance or serious mental health problems
  - A child deemed to be at risk has failed to attend out-patient or other health appointments
- 9.11.2 See Health Trust policy for detailed guidance.

### CHILD PRESENTED AT HOSPITAL

- 9.11.3 If any staff members (of whatever profession and however junior) have concerns about the welfare of a child they must inform their manager or the child's consultant or the named doctor or nurse and record the discussion / consultation.
- 9.11.4 Whenever medical or nursing staff see a child at A & E or on the ward with possible signs of abuse or neglect they must alert the consultant paediatrician or named nurse.
- 9.11.5 If abuse or neglect is suspected the child must at a minimum be examined by a specialist registrar in paediatrics, who must discuss the case with the consultant paediatrician.
- 9.11.6 No child who is thought to have been abused or neglected should be sent home without being examined by a senior paediatrician or with the permission of, a consultant paediatrician:

## ADDITIONAL PROCEDURES

- 9.11.7 If the child is presented in the night and admitted, it is possible to delay the consultation until the next day. In these circumstances, consideration must be given to potential safety issues of any siblings.
- 9.11.8 A senior paediatrician must see all children brought to hospital by Police, Children's Social Care staff or staff of another public agency.

### Referral to Children's Social Care

- 9.11.9 Once a concern is raised at the hospital, Children's Social Care must be informed without delay on its dedicated number and confirming on the health referral form CSF3155, which must be faxed within twenty four hours.
- 9.11.10 If a parent wishes to discharge the child from hospital against medical advice and there are concerns for the welfare of the child, Children's Social Care must be contacted urgently. Hospital staff cannot prevent the parent from leaving the ward with her/his child, but Police and Children's Social Care must be contacted immediately.

### Strategy discussions

- 9.11.11 A strategy discussion must be held whenever a professional or agency has raised child protection concerns about a child admitted to hospital, and this includes:
- Concerns relating to incidents or circumstances that may have arisen either prior to or during the hospital stay (including pre-birth concerns)
  - Circumstances in which differing opinions are held between professionals about the origin of an injury or the risks to the child
- 9.11.12 The participants should include the consultant in charge of the child (or suitable delegated health professional), Children's Social Care, Police CAIU and other relevant agencies and health professionals.
- 9.11.13 The meetings should be held at a location, which facilitates the attendance of key participants e.g. the hospital.
- 9.11.14 The strategy discussion should consider (in addition to the normal strategy discussion agenda see [6.7](#)):
- Cause/s for concern
  - Medical and nursing assessments
  - Timetable for discharge, if known
  - Pre-discharge planning required (see below)
  - Need for further strategy discussions or a pre-discharge meeting (see [9.11.19 -9.11.21](#) below)

**Consultation with designated / named doctor / nurse**

- 9.11.15 If it is unclear whether an injury has a non-accidental cause, or there is a difference of opinion within the medical team, the consultant in charge of the child's care should seek a second opinion either from the designated / named child protection doctor or from a specialist consultant.
- 9.11.16 If achievable the second opinion should be available to the strategy discussion.
- 9.11.17 Other agencies particularly Children's Social Care need to be made aware that a second opinion has been requested and the consultant in charge of the child's care should advise on the anticipated timescale.
- 9.11.18 Even if there is no clear diagnosis of non accidental injury in the medical report, an assessment of need and risk should be made.

**Pre-discharge planning meetings / reconvened strategy meetings**

- 9.11.19 If the strategy discussion did not cover the pre-discharge planning, a meeting must be arranged sufficiently early to ensure that a pre-discharge plan is in place before the child becomes medically fit for discharge.
- 9.11.20 The discussions and outcome of pre-discharge planning must be recorded in the child's health record at the earliest opportunity and before going off duty that day by the senior doctor attending.
- 9.11.21 The purpose of the pre-discharge planning is to:
- Consider the medical and social reports about the cause of concern
  - Consider the social work / multi-agency assessment/s of the risks to and the needs of the child, including 'home safety' informed (wherever practicable) by a home visit by a social worker
  - Consider the needs / risks in relation to other children in the family
  - Clarify on-going medical care
  - Ensure the child is registered with a GP
  - Identify support needed for those caring for the child once discharged
  - Formulate a multi-agency plan on discharge from hospital that address's the risks / concerns raised in respect of the child
  - Agree contingency plans should the child fail to attend planned follow up health appointments
  - Agree timescale for discharge, once the child is medically fit

### Chair of pre-discharge meeting

9.11.22 The social work team manager or the consultant / senior paediatrician should chair these meeting and may give guidance on which health professionals need attend.

### Possible attendance of pre-discharge meeting

9.11.23 The potential members of a pre-discharge planning meeting are:

- Consultant (or designated deputy)
- Social worker/s
- Social work team manager or senior practitioner
- Police officer CAIU
- Ward staff
- Paediatric liaison health visitor / health visitor and midwife (if child is new born)
- Staff from any specialist units to be involved post discharge e.g. burns unit
- School nurse
- GP
- Designated / named nurse
- Any other professional with information to assist with decision making

9.11.24 Though parent/s would not normally attend the pre-discharge meeting they will need to be informed, by the chair (or other agreed professional) of any decisions made at it.

### Quoracy

9.11.25 To be quorate, the meeting must be attended by representatives from the Primary Care / Health provider, Children's Social Care and hospital medical and nursing staff.

### Records of meeting

9.11.26 The chair should ensure there is a brief record of the discussion and 'agreed plan'. This record must be provided to all those attending within one working day.

9.11.27 It is the responsibility of the agencies present to ensure appropriate onward communications; e.g. the health agency must share its record with the GP, health visitor, school health advisor, named nurse and (if the child is looked after) notify the designated nurse for looked after children.

## ADDITIONAL PROCEDURES

- 9.11.28 The chair of the meeting must ensure that a handwritten copy of the decisions agreed at a pre-discharge planning meeting are placed on the child's medical notes directly after the meeting and this must be left at the hospital.
- 9.11.29 If an incident number has been raised with the Police, this should also be recorded.
- 9.11.30 The social worker should ensure the decisions of the meeting are recorded on the database immediately and consider raising an EDT alert if database recording is not immediately possible.

### Timescales for pre-discharge planning meetings

- 9.11.31 As soon as medical staff are able to predict the child's fitness for discharge, they should convene the pre-discharge meeting and thus provide an opportunity for professionals to undertake checks, read files and attend the meeting.
- 9.11.32 Because an assessment of risk must be concluded before the child is ready for discharge, a pre-discharge planning meeting will normally be convened within twenty four hours of it being called. This narrow time-frame requires a high level of flexibility and co-operation between professionals.

### GP registration

- 9.11.33 No child about whom there are concerns about abuse or neglect should be discharged from hospital without an identified GP.
- 9.11.34 The Nurse in charge must ensure that the hospital Consultant Paediatrician knows if a child is not registered with a GP. Arrangements have been agreed with the Practitioner Services Unit as follows:
- General enquiries (to obtain the name of a GP) 01707 390855 (Charter House Switchboard)
  - Specific request for GP to be allocated:
    - Registration Manager: 01707 361275
    - Secure Fax: 01707 361302
    - Mobile: 07789 935584

### Parental support

- 9.11.35 The 'pre-discharge planning meeting' should clarify how the parents will be supported and who will undertake this role.

## ADDITIONAL PROCEDURES

### At discharge

- 9.11.36 It is the responsibility of the nurse in charge at the time of discharge to ensure that follow up arrangements have been clearly documented.
- 9.11.37 It is the responsibility of the child's consultant to ensure that junior doctors write discharge summaries, which include any concerns:
- About the child's welfare, including child protection
  - As well as medical issues
- 9.11.38 Follow up arrangements must include clear and specific documentation about what to do if the child fails to attend out patient appointments or any other health appointments.
- 9.11.39 The senior nurse must ensure that a discharge checklist is completed and filed in the child's health record. The checklist should include (example and not exhaustive):
- Action plan completed and by whom
  - Address and details of parent / carer where the child is being discharged to
  - Next out patient appointment
  - Who to inform if the child fails to attend
  - Other follow up arrangements
  - CP advisor / named nurse / named doctor informed
  - Health visitor notified
  - Social worker notified
  - Community children's nurse notified
  - Liaison health visitor informed
  - School nurse informed
  - GP letter
  - Discharge summary
  - Medication dispensed
  - Parent held record completed

### Following discharge

- 9.11.40 Within two working days of discharge the GP for the child must be sent:
- A typed discharge letter
  - A copy of the hospital's referral form to Children's Social Care
- 9.11.41 The health visitor or school nurse (depending on the age of the child) must be provided with a copy of this correspondence.

## ADDITIONAL PROCEDURES

### MATERNITY UNIT & MIDWIFERY

- 9.11.42 Whenever there have been any child protection concerns about a new born baby (including concerns pre-birth), the ward should liaise with the Named Midwife for Child Protection & lead Midwife as part of discharge planning to ensure provision of appropriate postnatal care.
- 9.11.43 Discharge planning from the neonatal unit should include liaising with the senior neonatal nurse, GP, health visitor and Children's Social Care so that appropriate follow up support is provided.
- 9.11.44 A discharge planning meeting (as described above) should be convened at the hospital before the baby is discharged if:
- Children's Social Care has undertaken a pre-birth assessment (irrespective of outcome)
  - Any child protection concerns have arisen before, during or subsequent to the birth
- 9.11.45 Maternity hand-held records should be returned as soon as possible to maternity records as per normal practice.

### DISCHARGING A CHILD INTO CARE OF PARENTS WITH LEARNING DISABILITIES / SUBSTANCE MISUSE OR SERIOUS MENTAL HEALTH PROBLEMS

- 9.11.46 If a child is to be discharged to parents / carers with learning disabilities, substance misuse or serious mental health problems a multi-agency / professional pre-birth assessment should have been undertaken. If not, it should be undertaken prior to discharge.
- 9.11.47 A multi professional pre-discharge meeting must also take place to ensure a comprehensive plan is in place to support the parents / carers.
- 9.11.48 It is the responsibility of the nurse in charge of the ward to liaise with Children's Social Care to arrange this meeting.
- 9.11.49 If a nurse or other health professional is still concerned about a parent's competence, s/he must record any concerns and inform the senior nurse and child's consultant.

### OUTPATIENT OR OTHER HEALTH APPOINTMENTS

- 9.11.50 When it is known that a child is subject to a child protection plan, Children's Social Care should be informed, in writing, of any failed health appointments. It is the responsibility of the clinician who the child is due to see in the outpatient department to ensure this is done.

## ADDITIONAL PROCEDURES

- 9.11.51 For other children who fail to attend health appointments, where the clinician has/ is aware of concerns about their welfare s/he must discuss this with their supervisor or named / designated doctor or nurse to decide on further action. Any discussion about the child must be fully documented in the child's health record.
- 9.11.52 Any child who has been identified as vulnerable and who fails to attend an outpatient appointment must have their notes reviewed by the consultant paediatrician who will determine any necessary further action.

## 9.12 INTERPRETERS, SIGNERS & OTHERS WITH SPECIAL COMMUNICATION SKILLS

- 9.12.1 All agencies need to ensure a capacity to communicate fully with parents and children when there are concerns about abuse / neglect and to ensure family members and professionals fully understand the exchanges that take place.

### RECOGNITION OF COMMUNICATION DIFFICULTIES

- 9.12.2 When taking a referral social workers must establish the communication needs of the child / parents and other significant family members. Relevant specialists may need to be consulted e.g. language therapist, teacher of hearing impaired children, paediatrician etc.
- 9.12.3 The use of **accredited** interpreters, signers or others with special communication skills must be considered whenever undertaking enquiries involving children and/or family:
- For whom English is not the first language (even if reasonably fluent in English, the option of an interpreter must be available when dealing with sensitive issues)
  - With a hearing or visual impairment
  - Whose disability impairs speech
  - With learning difficulties
  - With a specific language or communication disorder
  - With severe emotional and behavioural difficulties
  - Whose primary form of communication is not speech
- 9.12.4 Family members should not be used as interpreters within the interviews although can be used to arrange appointments and establish communication needs.

## INTERVIEWING CHILDREN WITH COMMUNICATION DIFFICULTIES

- 9.12.5 The particular needs of a child who is thought to have communication problems should be considered at an early point in the planning of the enquiry (strategy discussion stage).
- 9.12.6 Professionals should be aware that interviewing is possible when a child communicates by means other than speech and should not assume that an interview, which meets the standards for purposes of criminal proceedings, is not possible.
- 9.12.7 All interviews should be tailored to the individual needs of the child and a written explanation included in 'Hertfordshire Constabulary Record of Interview Plan' about any departure from usual standards.
- 9.12.8 Every effort should be made to enable such a child to tell her/his story directly to those undertaking enquiries. It may be necessary to seek further advice from professionals who know the child well or are familiar with the type of impairment s/he has e.g. paediatrician at the child development centre or for child's school, social worker from the disabled children's team.
- 9.12.9 Para. 2.39 of *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children 2002* indicates that if the child is very young, very traumatised, has an idiosyncratic or very specialised system of communication, an 'intermediary' rather than an interpreter may be required i.e. someone who knows both the child and her/his way of communication (intermediaries must not be witnesses to fact in the case).

### Video interviews:

- 9.12.10 *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children 2002* provides guidance on interviewing vulnerable witnesses, including children, and of the use of interpreters and intermediaries. See also [6.9.10](#) for procedures relevant to investigative interviews.
- 9.12.11 Interviews with witnesses with special communication needs, may require the use of an interpreter or an intermediary, and are generally much slower. Para.2.147 of the above guidance indicates that for some children, a number of shorter sessions may be preferable to a single interview.

## ADDITIONAL PROCEDURES

- 9.12.12 A witness should be interviewed in the language of their choice and vulnerable or intimidated witnesses, including children, may have a supporter present when being interviewed. Note though, para.2.42 and 2.43 of the ABE Guidance which indicates that 'persons involved in the case in any capacity cannot take on the role of witness supporter. This would include a parent to whom the child first disclosed abuse, or a parent whose partner or former partner is the subject of an allegation of abuse. It is important to ensure that the Interview supporter has not been involved, nor perceived by the child as having been involved in the alleged offence.

## USING INTERPRETERS WITH FAMILY MEMBERS

- 9.12.13 If the family's first language is not English and even if they appear reasonably fluent, an interpreter should always be arranged as it is essential all issues are understood and fully explained.
- 9.12.14 Interpreters used for child protection work in Hertfordshire are subject to references, CRB checks and a written agreement regarding confidentiality (see CSF Communication Unit - Interpretation & Translation Service 'Interpreters' *Code of Practice* June 2006).
- 9.12.15 When a social worker asks for interpreting support, the Interpreting & Translation Co-ordinator should identify an appropriate interpreter who is available and agrees the assignment.
- 9.12.16 The interpreter's details should be given to the social worker who should then contact that individual to fine tune arrangements about time / place and to clarify:
- The interpreter's role in translating direct communications between professionals and family members
  - The need to avoid acting as a representative of the family
  - When the interpreter is required to translate everything that is said and when to summarise
  - That the interpreter is prepared to translate the exact words that are likely to be used – especially critical for sexual abuse
  - When the interpreter will explain any cultural issues that might be overlooked (usually at the end of the interview, unless any issue is impeding the interview)
  - The interpreter's availability for other interviews and meetings
- 9.12.17 Generally, interpreters should not be asked to undertake document translation (which is carried out by a Hertfordshire agency). If illiteracy is an obstacle to understanding, the social worker and interpreter may go through with the service user, a translated written report. This ensures that the service users have a copy in their own first language for future reference (with help if need be).

## ADDITIONAL PROCEDURES

- 9.12.18 Family members may choose to bring along their own interpreter as a supporter.
- 9.12.19 Invitations to child protection conferences and reports must be translated into a language / medium that is understood by the family and if there is doubt as to an invitation will be understood (even in translation) the interpreter may be asked to phone the family and provide the necessary details.

## 9.13 LOOKED AFTER CHILDREN

### CHILD PROTECTION ENQUIRY

- 9.13.1 In any situation in which there is reason to suspect that a 'looked after' child is suffering, or is likely to suffer, significant harm formal s.47 enquiries must be initiated and the social worker must inform the Head of Service for Looked After Children, Children's Social Care
- 9.13.2 A member of the Childcare Litigation Unit should be involved in strategy discussions.

### REVIEWS, CARE PLANNING & CONFERENCES

- 9.13.3 When CSF share parental responsibility as a result of a court order, careful consideration should be given to the need to maintain a child protection plan (doing so could indicate that the local authority had failed to appropriately exercise its parental responsibility).
- 9.13.4 A looked after child who remains the subject of a child protection plan will have both LAC reviews and child protection conference reviews. The LAC review should be arranged so as to follow the child protection conference.
- 9.13.5 Child care reviews and child protection conferences are separate meetings with different purposes. The plans made at child care reviews must be consistent with the protection plan.
- 9.13.6 When a looked after child review or other local authority planning meeting proposes any change which might significantly affect the level of risk of a child subject to a child protection plan e.g. return home to parents, the decision must not be implemented until it is considered by a review conference, **unless** it is part of the existing protection plan.
- 9.13.7 If there is disagreement within the subsequent child protection conference about the proposed change suggested by the LAC review, the situation must be brought to the attention of the operational service manager, who in consultation with the Head of Child Protection, will decide whether or not to proceed with the change.

## ADDITIONAL PROCEDURES

- 9.13.8 When a child is subject to a child protection plan and is removed from accommodation by parents or child is returned to parents or carers in court proceedings, against the recommendation of the local authority, a review child protection conference must be convened to consider the risks to the child and the implications for the protection plan.
- 9.13.9 If necessary the local authority must take action to protect a child prior to a conference. This must not be delayed until a child protection review is convened if an enquiry or assessment indicates it is required sooner.
- 9.13.10 For relevant related procedures see:
- Allegations against those working with children (module 10)
  - Abuse by children (see 9.2)

## DISCONTINUATION OF CHILD PROTECTION PLAN

- 9.13.11 When a looked after child is no longer living in the situation which gave rise to the decision to make her/him subject of a child protection plan and there is no current plan for her/him to be returned, her/his child protection plan may be discontinued, by means of a child protection conference decision.
- 9.13.12 In these circumstances the LAC care plan must include any elements of the child protection plan that remain valid.
- 9.13.13 Should the care plan subsequently include returning the looked after child to the situation that previously resulted in a decision to make her/him subject of a protection plan, a child protection conference must be held first to consider if a child protection plan is required.

## 9.14 MISSING CHILD, ADULT OR FAMILY

### CIRCUMSTANCES COVERED BY THE PROCEDURES

- 9.14.1 This section provides procedures that apply to:
- All children missing education and
  - Specific welfare concerns about a child or family

### GENERAL PROCEDURES FOR ANY CHILD MISSING EDUCATION

- 9.14.2 According to LEA/0225/2004 '*Identifying and Maintaining Contact with Children Missing or at Risk of Going Missing from Education*', there should be a 'child missing from education' (CME) named point of contact in every local authority and every practitioner working with a child has a responsibility to inform that CME if s/he knows or suspects that a child is not receiving education.

## ADDITIONAL PROCEDURES

### Locating pupil missing education

- 9.14.3 Should a child leave a Hertfordshire school without notice being given by the parent or without the school being advised by the parent of the new address and/or school the child is to attend, the school should notify their allocated Education Welfare Officer (EWO) as soon as possible:
- 9.14.4 The Education Welfare Officer will work with the school to make reasonable enquiries to try to identify the child's whereabouts
- 9.14.5 If after four weeks, enquiries fail to locate the child the school should remove the child's name from its roll and create a 'lost' common transfer file (CTF). 'XXX' should be used as the destination local authority and 'XXXX' as the destination school number. Each file should hold information on only one pupil. This lost CTF should be immediately up loaded onto the DfES s2s secure site where it should be held in the 'Lost Pupil Database'. 'XXX XXXX' should **only** be used when the school has no knowledge of the pupil's destination.
- 9.14.6 When a pupil moves to a non-maintained school or one outside England and Wales, the school should use 'MMMMMMM' as the destination code. This enables the CTF to be stored securely and to be available if the pupil returns to a maintained school.
- 9.14.7 Should a pupil leave a Hertfordshire school to be home educated, on receiving written confirmation from the parent/s, the school should remove her/his name from the school roll and send the CTF to the s2s Database using MMMMMM, so that the CTF goes into the database of pupils who have moved outside the maintained system (this does **not** apply to special schools).
- 9.14.8 Should a pupil join a Hertfordshire school without that school receiving a CTF from her/his previous school, the receiving school should contact the 'Lost Pupil Coordinator' and request that a search be made of the Lost Pupil Database for a matching record using gender, names or former names and date of birth. Schools cannot search the lost pupil database.
- 9.14.9 Should a Hertfordshire school which has previously sent a lost child CTF to the Lost Pupil Database be subsequently contacted by a school at which the lost child has subsequently registered, the:
- School which sent the CTF to the Lost Pupil Database should create a new CTF file and send it to the receiving school and request the Lost Pupil Coordinator to download the original CTF from the Lost Pupils database and delete it **and**
  - Receiving school should request its own LA to download the original CTF from the Lost Pupils Database.

## ADDITIONAL PROCEDURES

- 9.14.10 These procedures will only be effective if all schools adhere to the principle that whenever a pupil joins or leaves a school then a common transfer file **must** accompany her/him.
- 9.14.11 Further information on the transfer of a CTF can be found on [www.teachernet.gov.uk/s2s](http://www.teachernet.gov.uk/s2s)

## MISSING CHILD: ADDITIONAL PROCEDURES IF WELFARE CONCERNS

- 9.14.12 These procedures apply if a child in the following circumstances goes missing or cannot be traced:
- A child who is the subject of a child protection plan and who goes missing or is removed from her/his address outside the terms of the child protection plan
  - A child subject of a child protection referral or s.47 enquiry
  - A looked after child who leaves or is removed from placement, without this being part of the care plan
  - Any child known to a statutory agency who goes missing in suspicious circumstances or about whom there are concerns e.g. one who is subject to initial / Core Assessment, where there are developing concerns about their safety
- 9.14.13 These procedures also apply to adults whose whereabouts become unknown in the following circumstances:
- A pregnant woman when there are concerns about the welfare of the child following birth (and where the unborn baby's name may or may not be subject to a child protection plan)
  - A family where there are concerns about the welfare of the child because of the presence of an individual who poses a risk to children or other person suspected of previously harming a child

## Recognition & response by all agencies

- 9.14.14 Local agencies and professionals, working with children and families where there are outstanding child protection concerns, must bear in mind that unusual non-school attendance, missed appointments, or abortive home visits, may indicate the family has moved out of the area.
- 9.14.15 This possibility must also be borne in mind when there are concerns about an unborn child who may be at future risk of significant harm.
- 9.14.16 In any of the circumstances listed in [9.14.12-9.14.13](#) **all** agencies who become aware that the child, pregnant woman or family are missing must alert the responsible Children's Social Care social worker immediately.

**General response: Children's Social Care**

- 9.14.17 All reasonable steps need to be taken immediately to locate a missing child and alert other agencies with whom s/he may have contact.
- 9.14.18 Existing records in these agencies must be checked to obtain any information, which might help trace the missing child, e.g. details of friends and relatives.
- 9.14.19 The case needs to remain open and active steps must be taken to try to trace the child by visiting the last known address, checking with family members, any individuals known to hold parental responsibility and neighbours, if appropriate.
- 9.14.20 The following steps will need to be taken in all cases:
- A 'need to know' needs to be sent detailing the circumstances, (procedure in CSF Good Guide, form CSF 3645 on Connect)
  - Child/ren or family need to be reported missing to uniformed Police (who will alert CAIU) - if it is one child of the family missing, it may be most appropriate for the parents to do this - however it needs to be done as a matter of urgency, thus if the parents delay, Children's Social Care staff need to ensure it is done
- 9.14.21 If the child is subject to a child protection plan her/his name cannot be removed from the list of those for whom there is a child protection plan simply because s/he is missing, and:
- All members of the core group need to be updated and asked for any information they have about child/ren's possible whereabouts - and anything learnt should be passed to the Police
  - All relevant other local authorities must be notified (pass details of the nature and category of concerns, and key dates to the Child Protection Administrator, tel: 01992 556935, comnet 56935 who will do this – s/he will also notify Health Trusts in Hertfordshire)
  - (If a pregnant woman whose unborn child is subject of a child protection plan goes missing) hospitals need to be notified, either locally or nationally according to the circumstances
  - It may be helpful to bring forward the review conference so as to update all agencies and to revise the protection plan (in this case, the police officer in the case should be asked to attend)

**Further action by Children's Social Care, Health & Education Services**

- 9.14.22 Health records for **all** members of the family who are missing need to be tagged so that if their records are requested Health will be notified. The key /social worker should contact the health representative (health visitor / school nurse) for missing children and ask her/him to do this and to ensure GP records for all family members (including parents) who are missing are flagged.

## ADDITIONAL PROCEDURES

- 9.14.23 If the child is of school age, a note should be posted on the DfES database indicating the circumstances (e.g. subject of a child protection plan), that s/he has left her/his previous school and is currently missing. Anyone contacted about a school place for the child should then contact the social worker. The Principal Education Welfare Officer can assist (tel: 01992 588580 comnet 28580).
- 9.14.24 If the family is missing, or the child is of age to claim benefits, her/himself, the Department of Works & Pensions (DWP) need to be notified and asked to alert Children's Social Care if the family attempt to claim benefits.
- 9.14.25 If the child or family are known to the Immigration & Nationality Department (IND), it should be notified of the status of the child/ren and asked to contact Children's Social Care if it subsequently has any contact with the family.

### Child not found & subject to child protection plan

- 9.14.26 If the family remain missing and all reasonable steps have been taken a child/ren's names may, via agreement at a review child protection conference be removed from the list of those subject of a child protection plan.

## WHEN CHILD, FAMILY OR ADULT FOUND

- 9.14.27 When a child is found, there should, if practicable, be a strategy discussion within the working day between previously involved agencies to consider:
- Immediate safety issues
  - Whether to instigate a s.47 enquiry
  - Any police investigation of any allegations of crime
  - Who will interview the child if part of a s.47 enquiry
  - Who will interview the child if not a s.47 enquiry
  - Who (local and national) needs to be informed of the child's return
- 9.14.28 Any child found following a period missing should, regardless of whether s/he is believed to have experienced, or be at risk of, significant harm, be offered an interview by a social worker and/or a police officer or an independent person. This interview should provide a safe opportunity for the child to discuss any concerns regarding her/his care including if s/he chose to run away from an abusive situation. It must take place without parents, foster carers or residential staff either present or in close proximity.
- 9.14.29 If the child indicates a wish to be interviewed by an alternative professional, all reasonable efforts must be made to accommodate her/his wishes.

## ADDITIONAL PROCEDURES

- 9.14.30 If the child has been found outside of the local authority and is not likely to return, representatives of the 'receiving' authority must be involved in this strategy discussion and the transfer of the case must be discussed (see also module 12).

### Decision making

- 9.14.31 If the child is 'looked after', the Children's Social Care team manager must decide and record whether to bring forward the next child care review.
- 9.14.32 If the child is subject of a child protection plan, the team manager must decide and record whether to bring forward the next review conference.
- 9.14.33 Where a s.47 enquiry has taken place, the Children's Social Care, CAIU and other involved agencies must have a final strategy discussion to agree the outcome, including any need for a child protection conference.
- 9.14.34 The social worker and team manager must give explicit consideration to any need for legal action, and record the reasons for their decision.

## 9.15 NON COMPLIANCE

### INTRODUCTION

- 9.15.1 A feature in some serious case reviews has been the lack of co-operation and/or hostile attitude of parents / carers. When there are child welfare / protection issues, a failure to engage with the family may have serious implications and non-intervention is not an option. See also 9.14 (Missing Child, Adult or Family).

### DEFINITION

- 9.15.2 Parents may present in a number of ways on a continuum from hostility, threats and violence through to superficial and ineffective compliance. Behaviours may include:
- Ignoring advice / role of the professional
  - Misinterpreting / minimising the child's needs
  - Non attendance at medical appointments
  - Effectively preventing the child seeing the professional (blatant or agreeing to appointment then ensuring it does not occur)
  - Controlling discussion
  - Preventing meaningful contact with other parent / carer
  - Moving away

## ADDITIONAL PROCEDURES

- Manipulating and splitting professional relationships
- Subverting change
- Diverting discussions into arguments over e.g. the agenda
- Use of complaints
- Aggression and threats
- Evidence of implements of violence (dogs, knives etc)
- Known history of actual violence

## RESPONSE

### Good practice

- 9.15.3 It is helpful to be clear from the outset what is known about the family and parents / carers, so as to assess risks involved and potential strategies e.g. parents with learning difficulties or mental illness may need to have information, advice and expectations conveyed in an alternative way, possibly working with specialist colleagues.
- 9.15.4 Any written multi-agency plan must be reviewed regularly e.g. child's plan, reviewed at regular multi-agency meetings or child protection conference and use measurable objectives within timescales and specific outcomes, with a clearly stated contingency plan.
- 9.15.5 Communication should be clear, so as to ensure that non compliance is not caused by any misunderstanding.
- 9.15.6 Where there are child protection concerns parents / carers will need to understand that lack of co-operation is unacceptable, although there may be some flexibility of the degree and type of co-operation.
- 9.15.7 It will be helpful to establish trust through active engagement, acknowledging that the family may see things differently and demonstrating a respect for their views, whilst confronting inappropriate attitudes.
- 9.15.8 All decisions and communications must be recorded clearly and shared.
- 9.15.9 Staff must recognise when the family is not engaging so as to avoid collusion or avoidance – **early** recognition of resistance and failure to achieve progress with plans and agreements for the child is critical.
- 9.15.10 Supervision should be used to explore the dynamics of any hostility or non-compliance and plan how best to address the situation including possible specialist assessments.
- 9.15.11 A manager must be consulted if access is ever denied or appointments repeatedly cancelled and/or 'forgotten'.

## ADDITIONAL PROCEDURES

### Effect of non-compliance or hostility

- 9.15.12 In such situations, it is important to appreciate the significance for a child in the family i.e. it will enhance parent / carer's power and control and the child may fear reprisals if s/he were to speak to professionals.
- 9.15.13 Professionals may feel extremely vulnerable when visiting hostile families, especially those who challenge effectively and are perceived as a threat and professionals need to recognise and avoid the risk of putting more effort into dealing with the resistance, than addressing the real problems facing the child/ren.

### Action to take when non-compliance or hostility recognised

- 9.15.14 Professionals should report non compliance to their managers and to the social worker.
- 9.15.15 If there are child welfare concerns, the Children's Social Care team manager should convene a meeting. Sharing agencies' approaches, in accordance with information sharing arrangements may assist in forming an action plan.
- 9.15.16 The multi-agency / core group meeting should address the non co-operation in the context of the child's written plan. Depending on the circumstances this meeting could be:
- The 1<sup>st</sup> meeting which will devise the plan
  - A review multi-agency meeting, brought forward if necessary
  - A professional strategy discussion where there are child protection implications that may need to be addressed by a s.47 enquiry or initial child protection conference
  - A core group meeting brought forward if necessary
  - A review protection conference, brought forward if necessary
- 9.15.17 Possible strategies include:
- Joint visiting with colleagues within or external to the agency, (requesting help from Police if there is a physical risk)
  - Exploring the possibility of engaging other non hostile members of the family, if this does not increase the risk to anyone
  - Children's Social Care holding a legal planning meeting to clarify options e.g. Child Assessment Order, Interim Care Order

### When there are threats or incidents of violence

- 9.15.18 Where there are actual threats or incidents of violence they must be reported to the Children's Social Care team manager immediately and local 'Violence at Work' procedures followed in relation to supervision, support, recording and reporting incidents to the Police.

## ADDITIONAL PROCEDURES

- 9.15.19 Any response must take account of:
- Risks to children and other family members
  - Personal safety issues for staff
- 9.15.20 The experience of violence or threats to staff should be used as evidence of the situation of the family and included in assessments of the child's circumstances.
- 9.15.21 Violence towards staff is a multi-agency problem. If one agency has information a parent / carer is known to be violent, it must alert other agencies of the risks posed.

## 9.16 ORGANISED & COMPLEX ABUSE

### DEFINITION

- 9.16.1 Organised or complex abuse covers circumstances, which may involve a number of abusers and/or a number of children.
- 9.16.2 The abusers concerned may be acting in concert to abuse a child or children.
- 9.16.3 One or more of the adults involved may be using an institutional framework or position of authority to recruit children for abuse.
- 9.16.4 It reflects, to a greater or lesser extent, an element of organisation on the part of the adult/s involved and may involve:
- Aspects of ritual to aid or conceal the abuse of children
  - Child sexual abuse networks where adults plan and develop social contacts with children for purpose of gaining access to them
  - Abusive images of children or abuse of children through prostitution
  - Abuse in residential homes, boarding schools or other institutions
  - Adult/s who seek contact with children for improper reasons through leisure or welfare organisations

### GENERAL PRINCIPLES

- 9.16.5 Cases of organised abuse are often complicated because of the number of children involved, the serious nature of the allegations of abuse, the need for therapeutic input and the complex and time consuming nature of any consequent legal proceedings.
- 9.16.6 Such cases usually require the formation of dedicated teams of professionals from both the Police and Children's Social Care for the purpose of the investigation.
- 9.16.7 It is recognised that those who commit sex offences against children often operate across geographical and operational boundaries and the procedure takes into account the involvement of more than one local authority.
- 9.16.8 When an allegation involves a post holder who has a specified role within these procedures, the referral must be reported to an alternative (more senior) manager.
- 9.16.9 In all investigations of organised abuse, it is essential that staff involved maintain a high level of confidentiality in relation to the information in their possession without jeopardising the investigation or the welfare of the children involved.
- 9.16.10 Subsequent information generated throughout the investigation should only be shared on a 'need to know' basis.
- 9.16.11 These procedures must be implemented in conjunction with the procedures on abuse by those working with children where appropriate (see module 10).
- 9.16.12 For further guidance see also Complex Child Abuse Investigations: Inter-Agency Issues, HO & DH 2002  
[www.Police.homeoffice.gov.uk/news-and-publications/publication/operational-policing/child\\_abuse\\_guidance.pdf](http://www.Police.homeoffice.gov.uk/news-and-publications/publication/operational-policing/child_abuse_guidance.pdf).

### INITIAL STRATEGY DISCUSSION / MEETING

- 9.16.13 If there is a suspicion of a 'complex case', the Children's Social Care Head of Child Protection and the Police CAIU inspector must be informed immediately. They should have a management strategy discussion / meeting within the working day the referral is received.
- 9.16.14 The strategy discussion / meeting must:
- Assess the information known to date
  - Decide what further information is required at this stage

## **ADDITIONAL PROCEDURES**

- Arrange for its gathering
  - Establish if / to what extent complex abuse has been uncovered
  - Undertake an initial mapping exercise to determine the scale of the investigation and possible individuals implicated
  - Consider a plan including resource implications, for investigation to be presented to the management and resources strategy group
  - Consider any immediate protective action required
- 9.16.15 This management strategy discussion may include the referrer, if appropriate, a legal adviser and anyone else relevant to the discussion.
- 9.16.16 Having considered and discussed the information those persons must, if in their view the suspicion is confirmed, pass the information on to the Head of Children's Social Care & Community Service.

## **PROFESSIONALS WHO NEED TO BE INFORMED**

- 9.16.17 The Head of Children's Social Care must inform the LSCB chair, Director of Children's Services, head of the media / press office and senior managers of relevant agencies e.g. designated child protection professionals of a need for an investigation into organised and complex abuse.

## **STRATEGIC MANAGEMENT GROUP (SMG)**

- 9.16.18 To ensure a co-ordinated response, a SMG meeting chaired by either Children's Social Care or the Police must be convened as early as possible.
- 9.16.19 The membership of the group should comprise senior staff able to commit resources and will normally include the following as consistent core membership (additional members may be added as required as the investigation progresses):
- Head of Children's Social Care & Community Service
  - Chief Superintendent
  - Police senior investigating officer (usually CAIU DI)
  - Children's Social Care Children's Services Manager and CSF Head of Child Protection
  - Senior legal adviser (local authority)
  - Senior health representative, supported as necessary by designated professional
  - Press officer
  - Other individuals and agencies as appropriate

## ADDITIONAL PROCEDURES

- 9.16.20 Line managers of any staff implicated in the allegations of abuse must not be included in the SMG.
- 9.16.21 The terms of reference of the SMG must be set up as specified in the HO & DH guidance (see 9.16.12 above)
- 9.16.22 The SMG meeting must agree a plan that includes:
- A decision on the scale of the investigation and the staff required for a joint investigation group
  - Consideration of any cross boundary issues and planning of appropriate liaison and sharing of resources
  - Identification of staff in both Children's Social Care and the Police of sufficient seniority and experience to manage the investigative process (usually the CAIU DI and Children's Social Care service manager)
  - Identification of sufficient trained staff for the investigation (must be independent of those being investigated)
  - Organisation of adequate accommodation including a dedicated incident room and facilities for interviewing and recording interviews
  - Arrangements for medical staff to conduct assessments
  - Arrangements for sufficient administrative staff and information technology resources to support the investigation
  - Proper legal advice including consultation with the CPS
  - Sufficient resources to ensure that children are protected from further abuse and that their welfare remains paramount (this should include appropriate foster, day-care or residential placements, medical, therapeutic, educational and practical services)
  - Sufficient support, supervision and de-briefing of staff involved
  - Availability of expert advice where necessary
  - Liaison arrangements for inter-agency working
  - Time scales for the stages of the investigation
  - Allocation of specific tasks to personnel involved in the investigation together with line management responsibilities
  - Management of public relations and media interest in the case
  - Child witness support, if relevant
- 9.16.23 An individual must be designated to act as co-ordinator between the SMG and the joint investigative group identified in the plan, usually the Police senior investigating officer or the Children's Social Care lead manager.
- 9.16.24 The responsibility of the co-ordinator is to manage the joint investigative group and prepare a report at the conclusion of the case.

## ADDITIONAL PROCEDURES

- 9.16.25 The SMG must make arrangements to convene regularly during the investigation to:
- Monitor the progress, quality and integrity of the investigation
  - Review risk indicators for the children involved
  - Consider resource requirements
  - Consider the appropriate timing of the termination of the investigation
  - Plan a de-brief meeting with the joint investigation group to identify lessons learnt
- 9.16.26 A dedicated team of Police officers may be formed to deal with a cross boundary enquiry.
- 9.16.27 The SMG should remain in existence at least until the court or the CPS has made a decision about the alleged perpetrators.
- 9.16.28 The SMG must report in writing to the LSCB, who must consider at the first available opportunity, whether a serious case review should be initiated.

## INVESTIGATION MANAGEMENT GROUP (IMG)

### Membership

- 9.16.29 The senior investigating officer or her/his deputy should chair the IMG. The IMG should include experienced personnel from CAIU and Children's Social Care – the latter may choose to use independent / agency / outside organisation social workers.
- 9.16.30 The size of the group will depend on the scale of the investigation, but in the majority of cases both CAIU and Children's Social Care should provide a line manager and two staff / officers experienced in interviewing children and trained in *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children 2002*.
- 9.16.31 Membership may also be drawn as necessary from the appropriate health professionals, in particular forensic medical examiners (FME), paediatricians, psychiatrists, health visitors, education (Head Teachers and class teachers), CPS, legal services, probation, victim support services.
- 9.16.32 In selecting staff, consideration should be given to requirements arising from the individual needs of the relevant child/ren i.e. gender, culture, race, language, and where relevant, disability.

## ADDITIONAL PROCEDURES

### Practical arrangements

- 9.16.33 The location of the group must take account, both geographically and organisationally, of the need to maintain confidentiality, especially crucial where the investigation concerns staff or carers.
- 9.16.34 Appropriate facilities must be available for video interviews and paediatric assessment.
- 9.16.35 Administrative support, information technology and accommodation requirements must be addressed at the outset, including the storage of confidential records.

### Responsibilities

- 9.16.36 The joint investigation group will be responsible for:
- Planning the overall investigation involving record checking, evidence gathering, planning and undertaking a series of interrelated interviews and any surveillance required
  - Considering the implications of crossing geographical boundaries (see below)
  - Maintenance of written records of regular strategy and operational meetings
  - Holding planning meetings for individual pieces of work e.g. video interview of a child and/or action to protect a child
  - Gathering other evidence including forensic evidence, interviews with alleged abusers, witnesses and other corroborative evidence
  - Communication and liaison with other agencies on a need to know basis
  - Convening interagency meetings and/or child protection conferences as appropriate
  - Co-ordination and timing of therapeutic services
  - Regularly updating the SMG on the progress made and recommending when to close the investigation
  - Consideration of arrangements for court hearings and support to children and families
  - Recommendations as to the placement of children and any contact involving children and their siblings, relatives or other adults

### CROSSING GEOGRAPHICAL & OPERATIONAL BOUNDARIES

- 9.16.37 It may be recognised at the outset or during the investigation that there are suspected or potential victims in more than one geographical area.

## ADDITIONAL PROCEDURES

- 9.16.38 At the outset, the responsibility for managing the investigation lies with the Children's Social Care where the abuse is alleged to have occurred/ where the alleged perpetrator/s are alleged to operate.
- 9.16.39 Once it is recognised that there are suspected or potential victims in other areas a joint approach should be made by the SMG to the appropriate Children's Social Care and CAIU.
- 9.16.40 The original joint investigation team should undertake the investigation on behalf of the other geographical areas.
- 9.16.41 A senior manager from each area should join the initiating SMG to discuss this and agree any resource implications involved.
- 9.16.42 If the number of victims outside the geographical boundaries of the original joint investigative team increases to the extent that it cannot respond, then a joint investigative team in the new geographic area should be established.
- 9.16.43 It is essential that there is a joint SMG to provide overall planning. If it is necessary to have more than one joint investigative team, there must be close working between co-ordinators and processes for full information sharing.

## 9.17 PARENTS WITH LEARNING DISABILITIES

### INTRODUCTION

- 9.17.1 The increasing awareness of families where one or both parents have learning disabilities has resulted in an increase in the number of referrals made to all agencies related to parenting issues. Research evidences the need to increase effectiveness of assessment, communication and joint working between professionals from different agencies if parents are to be adequately supported and children protected.
- 9.17.2 Hertfordshire's Protocol for the Assessment of Parents with Learning Disabilities (see [www.hertsdirect.org/safeguardingchildren](http://www.hertsdirect.org/safeguardingchildren) for details) provides the basis of multi-agency work for families where a parent / carer may have a learning disability.

### DEFINITION OF LEARNING DISABILITY

- 9.17.3 For the purpose of these procedures, the definition of 'learning disability' is based on that set out in the White Paper 'Valuing People' (2001):

## ADDITIONAL PROCEDURES

- A significantly reduced ability to understand new and complex information, to learn new skills (impaired intellectual functioning [IQ < 70]), with;
- A reduced ability to cope independently (impairment of adaptive and social functioning)
- Which started before adulthood, with a lasting effect on development

9.17.4 This is considered a 'pervasive' definition of learning disability and must be differentiated from a 'learning difficulty', which describes a range of conditions such as dyslexia that can lead to special educational needs.

## RECOGNITION & SCREENING OF PARENTAL LEARNING DISABILITY

9.17.5 It is not always clear whether or not a parent / carer has a learning disability, but the following information (if available) may help its identification:

- Reference to medical records can sometimes provide evidence
- Reference to educational records (where it is less than five years since leaving school) can provide evidence of a learning disability e.g. a statement of special education needs
- Personal history involving attendance at special schools
- Severe difficulties with literacy or numeracy (verbal reasoning often masks this difficulty)
- Enquiries made of the Learning Disability Register maintained by Adult Care Services

9.17.6 When a learning disability is suspected, practitioners should use the initial screening questions outlined in flowchart 1 overleaf (Referral to Learning Disability Team & Specialist Learning Disability Services).

9.17.7 The learning disability services are composed of health (SLDS) and social (CLDT) services working in partnership. The criteria for these services are based on different needs:

- SLDS criteria are based on diagnosis of pervasive LD, as per definition in 9.17.3 above
- ACS criteria relate to vulnerability and risk in relation to health and safety, autonomy, management of daily routines, involvement in family and wider community life

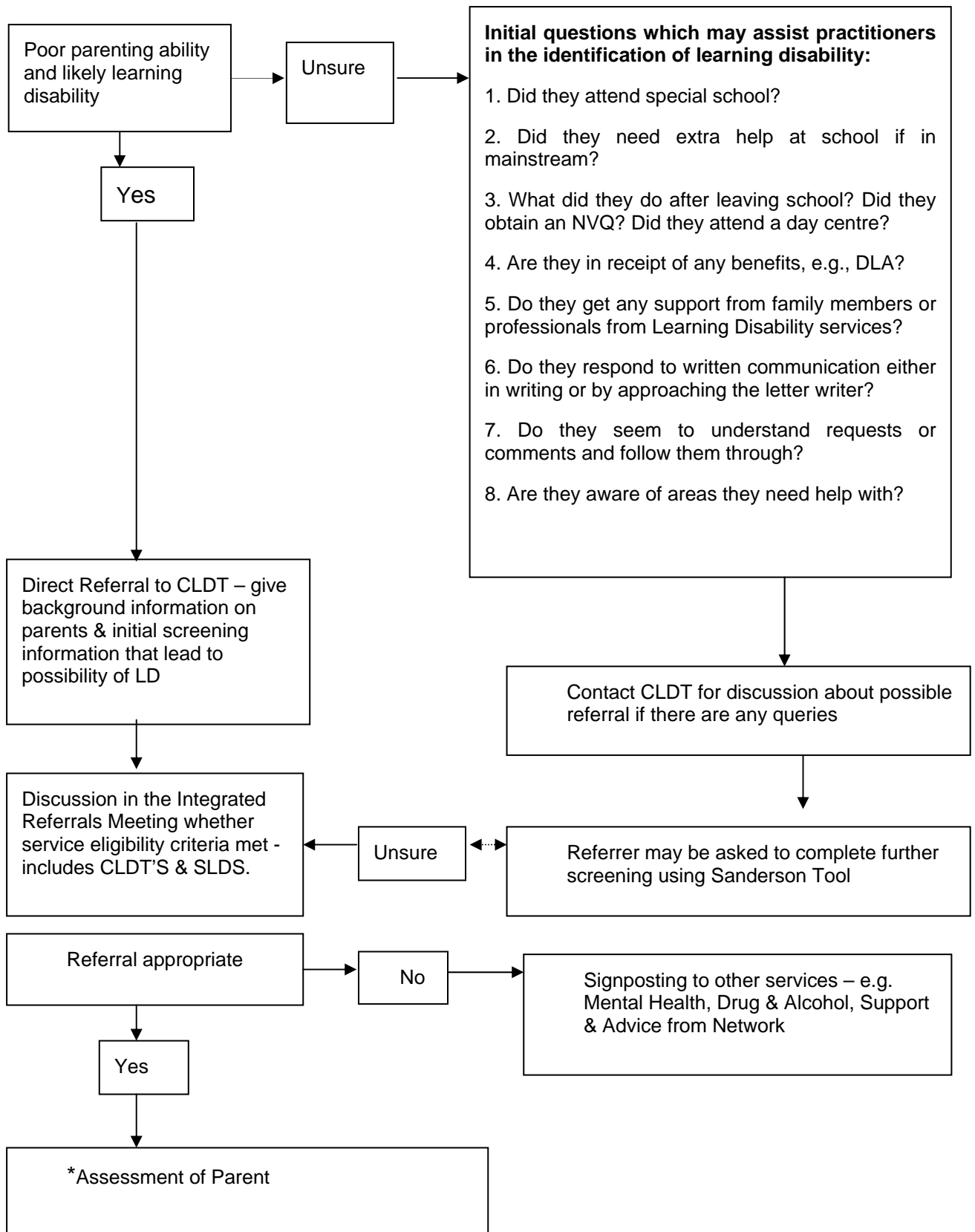
9.17.8 Following consideration of the initial screening tool consultation may be sought via the duty officer of the community learning disabilities team (CLDT) where professionals are unsure if parents (or prospective parents) meet eligibility criteria for the service.

## IMPACT OF PARENTAL LEARNING DISABILITY

- 9.17.9 The ability of parents with learning disability to provide a reasonable standard of care will depend on their own individual abilities, circumstances and the individual needs of the child.
- 9.17.10 The issues which most frequently give rise to concern in relation to parents with learning disabilities arise from a lack of skills, understanding or knowledge of the child's needs, rather than deliberate abuse. Consequently learning disabled parents may need considerable support to develop the understanding, resources, skills and experience to meet the needs of their child.
- 9.17.11 Such support is particularly important if they also experience additional stressors e.g. having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty or a history of growing up in care.
- 9.17.12 Para. 9.21 of *Working Together to Safeguard Children 2006* additionally states that children of parents with learning disabilities are at increased risk from inherited learning disability and more vulnerable to psychiatric disorders and behavioural problems.
- 9.17.13 Such increased stressors, when combined with parental learning disability, may lead to concerns about the care of children.
- 9.17.14 Learning disabled parents are sometimes targeted by individuals who may pose a risk to children and the children could in these situations be vulnerable to abuse and neglect.
- 9.17.15 Appendix 4 of the Hertfordshire Protocol for the Assessment of Parents with Learning Disabilities provides further details of research and of the links between neglect and parental learning disability.
- 9.17.16 Professionals should be alert to the possibility of significant harm and signs of neglect in children cared for by parents with learning disabilities. Children who may be more vulnerable are:
- Unborn babies or infants under one year old
  - Toddlers
  - Children with a disability or special educational needs
  - Children in a caring role
  - Children experiencing domestic violence
  - Parents with a history of violence or sexual abuse

ADDITIONAL PROCEDURES

**Flowchart 1: Referral to Learning Disability Team & Specialist Learning Disability Services** (reproduced from Protocol for the Assessment of Parents with Learning Disabilities)



*\*Children Schools and Families will always retain responsibility for completion of the initial and Core Assessments. When a child is at risk of suffering significant harm, however when an appropriate request for support/ specialist assessment is made, other agencies need to be mindful of the timescales, and referrals given high priority in line with the Child Protection Procedures.*

## ADDITIONAL PROCEDURES

- 9.17.17 Due to the increased vulnerability of this group of children they may require a rapid multi agency response to assess parent's learning disability and potential for adequate parenting.
- 9.17.18 The impact of the level of Learning Disability of parents needs to be formally addressed at appropriate stages in the management of a case of chronic neglect
- 9.17.19 Ultimately, regardless of whether or not the parent has a learning disability, the **quality of care experienced by the child** determines whether or not a referral should be made for assessment by Children's Social Care.

## MULTI- AGENCY WORKING

- 9.17.20 Effective working between professionals supporting parents with learning disability and those supporting children is at the core of effective systems to protect children. Each service will have its own criteria for prioritising referrals. This must not become an obstacle to co-operation at an early stage.
- 9.17.21 See also multi-agency case management [9.17.44 - 9.17.49](#)

## PRE-BIRTH NEED FOR MULTI-AGENCY SUPPORT

- 9.17.22 It is important to jointly assess the needs and plan any support for learning disabled parents as early as possible.
- 9.17.23 Where the prospective mother is known to the CLDT or it is known that she has a learning disability the GP and midwife should make referrals to the CLDT for an assessment of
- The pregnant woman's needs and capacity for self care and
  - Her ability to provide adequate care for the baby
- 9.17.24 This assessment should consider strengths and the nature of any support available from family and partner.
- 9.17.25 Where the mother is not known to the CLDT and the degree of disability is unclear, see [9.17.5 - 9.17.8](#)

## POST BIRTH NEED FOR MULTI-AGENCY SUPPORT

- 9.17.26 Where evidence of a learning disability is present in one or both parents, the paramount consideration of all the agencies will be the welfare and protection of the child/ren with each service providing assessment and support directed at the family members identified as the primary focus of that service's provision.

## ADDITIONAL PROCEDURES

### CONSULTATION &/OR REFERRAL TO CHILDREN'S SOCIAL CARE

- 9.17.27 'What if' consultations are available from Children's Social Care (see [3.5.27](#) if professionals are unsure whether to make a referral.
- 9.17.28 Staff in CLDT should refer to Flowchart 2: Checklist for Community Learning Disability Staff flowchart overleaf.

#### Pre-birth

- 9.17.29 If any professional or agency has **any** concerns about the capacity of the pregnant woman and her partner to self-care and/or to care for the baby, it should be discussed with the line manager / supervisor, recorded and a referral should be made to Children's Social Care in line with pre-birth procedures (see [4.18](#) and [9.19](#)).
- 9.17.30 Some parents with learning disabilities may not recognise that they are pregnant, and this should be considered if there are suspicions that a parent is concealing or has concealed a pregnancy.

#### Post-birth

- 9.17.31 If any professional or agency has any concerns about the capacity of the parent/s to self-care and/or to care for the child, a referral should be made to Children's Social Care in line with these procedures.

### ASSESSMENT & PLANNING

- 9.17.32 Where a parent meets the CLDT's threshold criteria, all assessments (CAF, pre-birth, Initial Assessment and s.47 enquiry) must involve CLDT and be in accordance with the Framework for the Assessment of Children in Need and their Families. The focus should include **all** parents / carers, regardless of their intellectual level and include the parent / carer's ability to:
- Recognise the child's needs, including emotional needs
  - Place needs of the child before their own
  - Anticipate the child's needs
  - Adapt to the growing and changing needs of the child
  - Learn and retain information (including consideration of different learning styles)
  - Use available support for themselves and their child/ren
- 9.17.33 The Parenting Assessment Manual (PAM) may be used as part of the multi-agency assessment of the parents (see appendix 2 of the Protocol for the Assessment of Parents with Learning Disabilities) for more information).

## ADDITIONAL PROCEDURES

- 9.17.34 Specialist assessments may also be appropriate e.g.:
- Cognitive functioning
  - Functional / living skills assessment
  - Emotional factors
- 9.17.35 Child protection plans should clearly focus on how to achieve better outcomes taking into account:
- The specialist assessments above
  - The way the parent/s / carers are able to understand and learn (see [9.17.38](#) - [9.17.42](#))
- 9.17.36 Additional support to child protection professionals in the way of consultation and/or supervision should be sought from specialist adult services both within CLDT and elsewhere in health in particularly complex cases.

## PARENTAL CONSIDERATIONS AS PART OF THE ASSESSMENT, PLANNING & SUPPORT PROCESS

- 9.17.37 Key meetings should be kept short to cope with the parent/s' attention span. Notes and plans may need to be adapted to be comprehended by the parent/s.
- 9.17.38 Consideration should be given to parents' needs for an independent advocate and/or a facilitator during the assessment phase.
- 9.17.39 Suitable methods for providing advice and helping to set routines should be identified e.g.:
- The parent may find it easier to learn in her/his own home to maximize transference of learned skills
  - Tasks broken down into small steps
  - Use of practical demonstrations and concrete examples
  - Instruction / information to match the parent's level of understanding and comprehension and include pictorial material
  - Provide more time for each process and task
  - Written agreements may be helpful, but will need to be very clearly written
- 9.17.40 The number of people involved in the network of support should be limited to avoid confusion and inappropriate intrusion.
- 9.17.41 The professionals involved must be clearly identified and communication pathways developed to facilitate a cohesive, coordinated service, that is supportive to all those involved.

## ADDITIONAL PROCEDURES

- 9.17.42 Parents / carers with learning disabilities are likely to require long term support to be able to meet their child's needs. Where this cannot be provided within the family or community, the parent is likely to require support from professionals. *Working Together to Safeguard Children* 2006 para. 9.25 refers to a study that concluded group education combined with home based support increased parenting capacity.

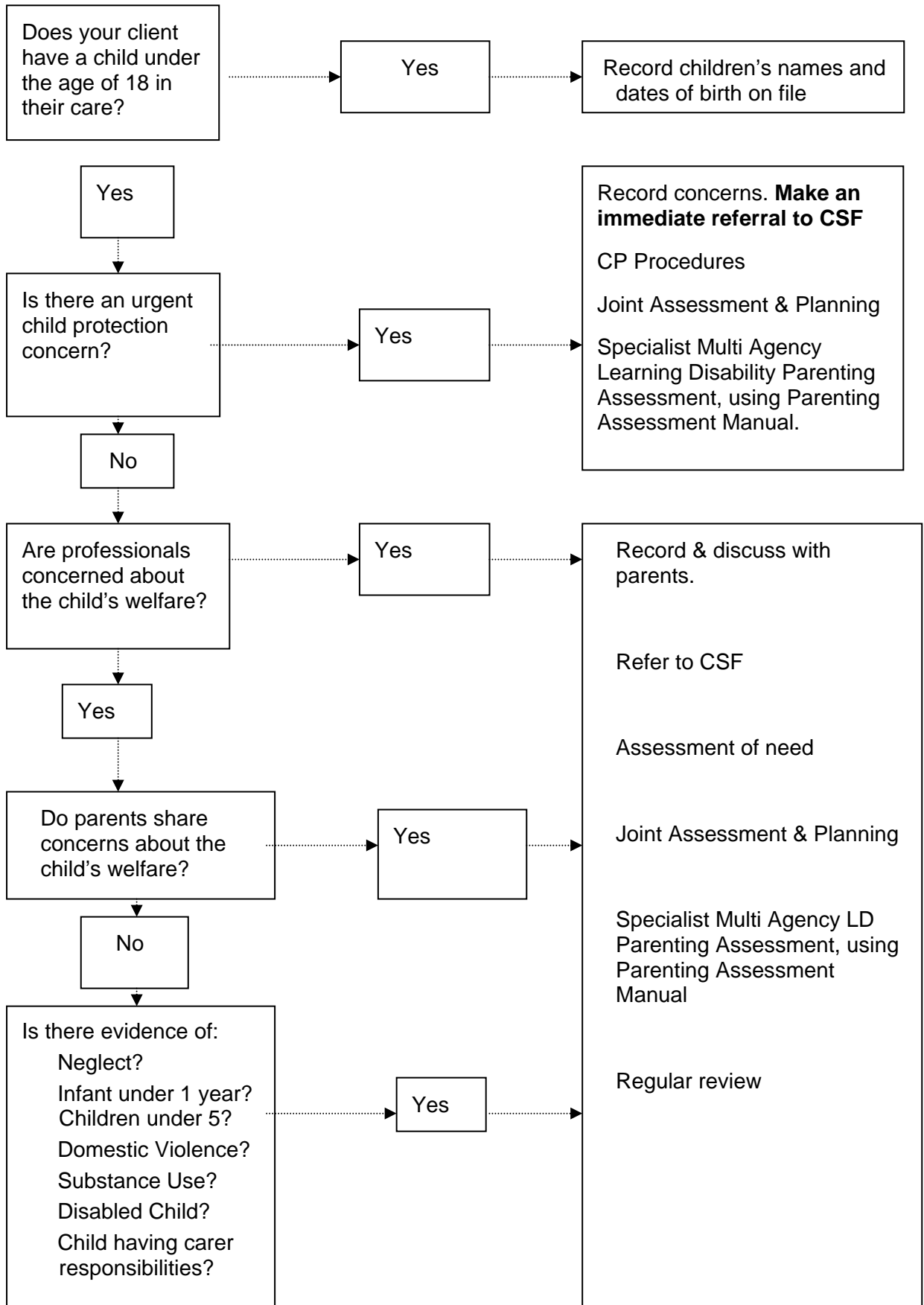
## MULTI-AGENCY CASE MANAGEMENT

- 9.17.43 To ensure effective working professionals must consider:
- Early communication and referral if it is suspected that a parent (or prospective parent) has a learning disability
  - Regular meetings should be held
  - Involving Speech and Language therapists when communication has been assessed to be a problem

### Multi-agency work as part of the child protection process

- 9.17.44 Joint working is essential as part of the child protection process (assessment, child protection conference decision making, core group planning and provision of support) and should take place from outset. This is to ensure appropriate services are provided by all agencies, needs are addressed, visits co-ordinated to avoid duplication and to prevent professional conflict.
- 9.17.45 *Cross Service Protocols, Delivering Social Care Across Service Boundaries*, November (2004) on Connect set out the managerial responsibilities in respect of all agencies
- 9.17.46 Children's Social Care key worker is responsible for case co-ordination.
- 9.17.47 Where parental health and/or social needs are identified, the CLDT should identify lead health and/or social professionals to support the parents.
- 9.17.48 Each service should consult with or advise colleagues in order to facilitate case management.
- 9.17.49 For cases that do not fit criteria for Learning Disability Services consultation and advice about assessment and intervention is available from the Hertfordshire Parenting Network (see appendix 1).

**FLOWCHART 2: CHECKLIST FOR COMMUNITY LEARNING DISABILITY STAFF** (reproduced from Protocol for the Assessment of Parents with Learning Difficulties)



## 9.18 PARENTAL SUBSTANCE MISUSE (INC. DURING PREGNANCY)

### RECOGNITION

- 9.18.1 Parental substance misuse of drugs or alcohol becomes relevant to child protection when it impacts on the care provided to their child/ren.
- 9.18.2 Substance misuse may include experimental, recreational, poly-drug, chaotic and dependent use of alcohol and / or drugs.
- 9.18.3 Misuse of drugs and/or alcohol is strongly associated with significant harm to children, especially when combined with other features such as domestic violence, mental illness and personality disorder.
- 9.18.4 The risk to child/ren may arise from:
- Use of family resources to finance parents' dependency, characterised by inadequate food, heat and clothing for children
  - Exposing children to criminal or other inappropriate adult behaviour
  - Unsuitable care givers or visitors - e.g. customer or dealers
  - Being passengers in a car being driven by a driver who has been drinking or using drugs
  - Effects of alcohol or drugs which may lead to dis-inhibited behaviours e.g. inappropriate display of sexual and/or aggressive behaviour
  - Chaotic drug use which may lead to increased irritability, emotional unavailability, irrational behaviour and reduced parental vigilance
  - Withdrawal symptoms including mood disturbances
  - Unsafe storage of drugs or injecting equipment
  - Adverse impact of growth and development of an unborn child
  - Risk to the newborn infant of being born with withdrawal syndrome
  - Increased risk of the child developing alcohol and drug use problems themselves (and associated risks of unwanted sexual encounters and injuries through fighting / accidents)
- 9.18.5 Parental non compliance with treatment plans should raise professional concerns about the risk to the children.

### INFORMATION SHARING

- 9.18.6 Partnership working across agencies is vital for effective assessments of risk and to ensure child/ren's safety and involves:
- Communication
  - Sharing of information
  - Co-ordination of responses

## ADDITIONAL PROCEDURES

- 9.18.7 In accordance with module 2 (Information Sharing & Confidentiality), information about parents with substance misuse problems should be shared with other relevant professionals if there are any concerns about the welfare of the child/ren or for the unborn child.
- 9.18.8 Care programme meetings regarding drug or alcohol abusing parents must include consideration of any needs or risk factors for the children concerned. Children's Social Care should be given the opportunity to contribute to such discussions.
- 9.18.9 Strategy discussions and child protection conferences must include workers from any drug and alcohol service involved with the family.

## REFERRAL TO CHILDREN'S SOCIAL CARE

- 9.18.10 If staff in drug and alcohol services have concerns regarding the care of the child (or unborn baby), they must discuss them with their line manager or supervisor.
- 9.18.11 If it is clear that a child is at immediate and serious risk an urgent referral must be made to Children's Social Care in accordance with modules 3, 4 and 5 of these procedures.
- 9.18.12 If there is any uncertainty about whether a referral is appropriate advice should be sought from the social work team duty manager / worker via a '**what if**' consultation (see [3.5.26 - 3.5.29](#))
- 9.18.13 Child care concerns which do not involve child protection can also be referred for advice and support on a child in need basis with the agreement of the parent / carer.
- 9.18.14 A GP who has concerns and is uncertain about the appropriate action should discuss with the 'named doctor' or 'named nurse' for child protection in her/his Trust.

## REFERRAL DURING PREGNANCY

- 9.18.15 If a professional is aware a pregnant woman or her partner is involved in significant substance misuse, a referral should, if there are concerns about the welfare of the baby during pregnancy or after the birth (see also [9.19](#) Pre-birth Procedures), be made as early as possible,
- 9.18.16 A referral must be made to Children's Social Care if one or more of the following criteria are met:
- A previous child has been removed or is living permanently with another carer
  - The woman has been using heroin, methadone, cocaine or comparable substances for a significant period

## ADDITIONAL PROCEDURES

- The woman is continuing to use heroin or misuse methadone and making insufficient preparations for her baby's arrival
  - Her use is characterised by multiple drugs / drugs and alcohol
  - Family's lifestyle is known or reported to be chaotic and / or unhygienic
  - Another household member is known or reported to be involved in significant substance misuse
  - The absence of extended family / friends able to provide extensive support to the substance misusing prospective parent/s
- 9.18.17 The midwifery service must initiate a phone and written referral as soon as it becomes aware of concerns relating to substance misuse, using a CSF3155H health referral form.
- 9.18.18 The midwife should ensure Hep B and HIV screening has been recommended to all drug abusers (Hep C screening is also recommended for intravenous users or for those who are Hep B or HIV+) and that the results are available in the hospital notes (see 9.19 for additional pre-birth procedures that apply in these circumstances).

## BABIES WITHDRAWING FROM SUBSTANCES

- 9.18.19 Where a baby is born suffering from withdrawal symptoms the midwives must refer the baby to Children's Social Care immediately. The baby has suffered significant harm and normal procedures described in modules 3,4 and 5 apply. Unless the baby is already the subject of a child protection plan, Children's Social Care should convene a strategy discussion with CAIU, medical professionals and any other relevant professionals (see also 9.11 for hospital discharge arrangements)
- 9.18.20 This discussion will need to decide and plan:
- The assessments to be initiated, including whether or not to initiate s.47 enquiries
  - If it is safe for the baby to be discharged / remain at home
  - Health and Children's Social Care plans to provide support and monitor progress
  - Arrangements for notification of discharge from hospital – Children's Social Care should be informed by hospital staff as early as possible prior to discharge (see 9.11)

## FURTHER GUIDANCE

9.18.21 See Hertfordshire's *Working with Substance Misuse Parents / Carers* on [www.hertsdirect.org/safeguarding](http://www.hertsdirect.org/safeguarding) for guidance on:

- Confidentiality
- Assessments (including in its appendix 1 guidelines for drug / alcohol workers and in appendix 3 a tool for social workers to use when assessing risks to children of substance misusing parents)
- Child protection conferences
- Substance misuse in pregnancy
- Case management & supervision
- Treatment, assessment and interventions
- Adult drug misuse treatment tiers and commissioning levels
- Drug & alcohol service provision in Hertfordshire

## 9.19 PRE-BIRTH PROCEDURES

### INTRODUCTION

9.19.1 UK law does not afford legislative rights to an unborn baby. In some circumstances though, agencies or individuals are able to anticipate a likelihood of significant harm with regard to the as yet unborn baby.

9.19.2 Such concerns should be addressed as early as possible to maximise time for:

- Full assessment, including locating of any previous children
- Enabling a healthy pregnancy
- Supporting parents (where possible) to provide safe care
- Early identification of significant relative or family member who might be able to support or provide primary care

### COMMON ASSESSMENT

9.19.3 Health professionals in contact with pregnant women should routinely assess the needs of the mother and the unborn baby. The midwife should refer to the health visiting service as soon as any concerns are identified and consideration also given to the welfare of siblings.

9.19.4 A joint assessment may be undertaken e.g. a common assessment (CAF) between the midwife, health visitor and other professionals involved with the family. However, this process must not delay a referral being made to Children's Social Care when there is a risk of significant harm to the unborn baby

## ADDITIONAL PROCEDURES

### REFERRAL TO CHILDREN'S SOCIAL CARE

- 9.19.5 Any professional working with expecting parents who has concerns in relation to the welfare of the unborn baby must discuss and analyse them with her/his line manager or supervisor.
- 9.19.6 If it appears that there is a risk of significant harm to the unborn baby a referral must be made to Children's Social Care. At any stage professionals may wish to consult Children's Social Care about the appropriateness of a referral (see [3.5.26](#) -[3.5.29](#)).
- 9.19.7 A GP who has concerns and is uncertain about the appropriate action should discuss the concerns with the 'named doctor' or 'named nurse' for child protection in her/his Trust.
- 9.19.8 Concerns should be shared with prospective parent/s and consent obtained to refer to Children's Social Care unless this action in itself may place the welfare of the unborn child at risk e.g. if there are concerns that the parent/s may move to avoid contact.
- 9.19.9 Child care concerns which do not involve child protection can also be referred with the agreement of the parent for advice and support, on a child in need basis.
- 9.19.10 Information provided by the referring agency should follow the *Framework for the Assessment of Children in Need and their Families* format to facilitate its inclusion in the Initial Assessment.

### Timescales for referral

- 9.19.11 If agencies or individuals anticipate prospective parents may need support services to care for a baby or that s/he may be at risk of significant harm, a referral to Children's Social Care must be made at the **earliest** opportunity.
- 9.19.12 Delay must be avoided when making referrals in order to:
- Provide sufficient time to make adequate plans for protection
  - Provide sufficient time for a full and informed assessment
  - Avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time
  - Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome to assessments
  - Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth
  - Identify significant family members who might be able to provide support and consider the use of a family group conference to facilitate this

### Circumstances when referrals must be made to Children's Social Care

- 9.19.13 Referral must **always** be made for a pre-birth assessment in any of the following circumstances:
- There has been a previous unexpected death of a child whilst in the care of either parent where abuse /neglect is/was suspected
  - A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children
  - Children in the household / family currently subject to a child protection plan or previous child protection concerns
  - A sibling (or a child in the household of either parent) has previously been removed from the household either temporarily or by court order
  - There is knowledge that parental risk factors e.g. domestic violence, mental illness / impairment or substance misuse may impact on the unborn baby or child's safety or development
  - There are concerns about parental ability to self care and/or to care for the child e.g. unsupported young or learning disabled mother
  - There are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non compliance with treatment with potentially detrimental effects for the unborn baby
  - Any other concern exists that the baby may be at risk of significant harm, including a parent previously suspected of fabricating or inducing illness in a child
- 9.19.14 Where the concerns centre around a category of parenting behaviour e.g. substance misuse, the referrer must make clear how this is likely to impact on the baby and what risks are predicted.
- 9.19.15 All pregnant girls under the age of sixteen have by definition had unlawful sexual intercourse and should be referred to Children's Social Care (or the police) whenever abuse and exploitation has been suspected (see [9.21 Sexual Exploitation](#) & [9.23 Underage Sexual Activity](#)).
- 9.19.16 In some cases relevant records identifying one or more of the above risk factors may only be available to the GP e.g. where an adult has moved frequently. The GP must therefore consider the need for an early referral of the unborn baby when any of the above factors apply to a prospective mother, father or carer.

## CHILDREN'S SOCIAL CARE RESPONSE TO REFERRALS

- 9.19.17 Children's Social Care should undertake an Initial Assessment on all pre-birth referrals, unless this has already been undertaken by the referrer e.g. via a common assessment (CAF).
- 9.19.18 Children's Social Care may decide to refer the parent/s to other agencies for advise/support when there are no child protection concerns: this may be after the Initial Assessment or after a multi-agency meeting (see below).
- 9.19.19 A s.47 enquiry and Core Assessment should always be undertaken when there appears to be any risk of significant harm to the unborn baby. This decision may be made at any point in the assessment process. If the s47 enquiry concludes the unborn child is at risk of significant harm an initial child protection conference must be held.
- 9.19.20 In situations where the pregnancy has been concealed, when it is imperative to elicit the Police information in detail or where the parents are not co-operating with the process, a s.47 enquiry must be initiated.

### Multi-agency meeting or strategy discussion

- 9.19.21 Children's Social Care should convene a **multi-agency meeting** within ten days of the referral to consider concerns in relation to the welfare of the unborn baby and to initiate a pre-birth Core Assessment and any other specialist assessments.
- 9.19.22 When any of the criteria in 9.19.13 exist a multi-agency meeting must be held.
- 9.19.23 An up to date chronology and genogram must be provided for this meeting.
- 9.19.24 When it is possible to work in partnership with the parents and there are no immediate issues that could put the unborn baby at risk, a meeting under s.17 Children Act 1989 should be considered.
- 9.19.25 If it is suspected that the unborn baby may be at risk of significant harm the meeting should be in the form of a 'strategy discussion'.
- 9.19.26 A Children Social Care manager should chair the meeting and those invited should include a:
- Parents (if a multi-agency meeting)
  - Identified midwife
  - GP (where GP attendance is impossible the health visitor should collate relevant health information)

## ADDITIONAL PROCEDURES

- Likely health visitor
  - Police officer (if a strategy discussion)
  - Social worker
  - Other professions as appropriate e.g. obstetricians, mental health services, probation
  - Where required, a legal advisor (if a strategy discussion)
- 9.19.27 Legal advice should be obtained, and recorded, where there have been care proceedings on a child in the household of either parent.
- 9.19.28 This meeting should determine:
- Cause for concern and potential impact on care provided to the baby
  - Particular requirements of the pre-birth Core Assessment (see Hertfordshire Pre-Birth Assessment Guidance for more information [www.hertsdirect.org/safeguarding](http://www.hertsdirect.org/safeguarding))
  - Whether a s.47 enquiry is to be initiated
  - Role and responsibilities of agencies and specialists in the assessment e.g. involvement of expert in substance misuse if applicable
  - Role and responsibilities of agencies to provide support before and after the birth
  - Identity of responsible social worker to ensure planning and communication of information
  - Timescales for the assessments and enquiries, bearing in mind the expected date of delivery
  - How and when parent/s are to be informed of the concerns (if not already informed)
  - Required action by ward staff when the baby is born
  - The need for a pre-birth conference, or (where this will depend on the outcome of assessments) establish the date by which this decision must be made, given timescales in [7.2.22 -7.2.25](#)
- 9.19.29 If a strategy discussion has been held parents should be informed as soon as possible of concerns and need for assessment, except on the rare occasions when medical guidance advice suggests this may be harmful to the health of the unborn baby and/or mother.
- 9.19.30 The assessment plan must be consistent with standards required for possible court proceedings, including clear letters of instruction.

## PRE-BIRTH CORE ASSESSMENT

- 9.19.31 The overall aim of the assessment is to identify and understand for all involved prospective parents /carers:
- Parental and family history and structure, life style and support networks and their likely impact on the child's welfare
  - Causes of concerns and their likely impact on the baby's welfare
  - Parental needs
  - Strengths in the family environment
  - Factors likely to change and why
  - Factors that might change, how and why
  - Factors that will not change and why
  - Analysis of risk
- 9.19.32 Please refer to the Hertfordshire Pre-Birth Assessment Guidance on [www.hertsdirect.org/safeguarding](http://www.hertsdirect.org/safeguarding) for the components to be included in the assessment, including advice about specific situations of domestic violence, parental substance misuse, mental illness and parental learning disabilities and pregnancy of child.
- 9.19.33 Children's Social Care's responsible manager should determine, on the basis of the assessment, any need for a pre-birth child protection conference, to be held by 20 – 24 weeks of pregnancy.

### Developing a child protection plan or a child in need plan

- 9.19.34 If an initial child protection conference is held and it is agreed that a child protection plan is provided for the unborn baby, a core group meeting must take place at least 4 weeks prior to the expected date of delivery (EDD) and earlier if the baby is likely to be premature.
- 9.19.35 This meeting must make detailed plans of any actions to be taken and support to be delivered before and immediately following the birth.
- 9.19.36 Particular care should be taken to ensure representation of relevant agencies including maternity ward / midwifery in all cases and police / legal if the plan involves the removal of the baby at birth.
- 9.19.37 Where the initial conference did not agree to provide a child protection plan for the unborn baby, or where an initial conference was not held, a multi-agency meeting should be held with other agencies and the prospective parents. This should take place at least four weeks prior to the EDD (and earlier if the baby is likely to be premature) to formulate a child in need plan to support the parent/s and baby.

### When family plan to move / has moved

- 9.19.38 When there are significant concerns and the whereabouts of the mother are not known, Children's Social Care must inform other agencies and local authorities in accordance with procedures about missing child, adult or family in [9.14](#)
- 9.19.39 If there are significant concerns and the case is being transferred to another local authority, procedures in module 12 must be followed and transfer should not deter the originating authority from initiating or continuing care proceedings.

## 9.20 SELF HARM & SUICIDAL BEHAVIOUR

### DEFINITION

- 9.20.1 **Deliberate** self harm is an acute non fatal act of self harm carried out deliberately in the form of an acute episode of behaviour by an individual with variable motivation (Gelder et al 2001). The young person may have intentionally poisoned themselves through, for example, taking an overdose of medicines or injured themselves through self cutting, the damage caused is intentional. Deliberate self harm acts can be extremely serious and dangerous, characterised by intention to end life, or, there may be no intent to commit suicide. It is essential that all acts of deliberate self harm are taken seriously and the need for a referral made to specialist services for further assessment considered.

### RECOGNITION

- 9.20.2 The possibility that deliberate self-harm has been caused or triggered by any form of abuse or chronic neglect should not be overlooked.
- 9.20.3 The above possibility may justify a referral to Children's Social Care for an assessment as a child in need and/or in need of protection.
- 9.20.4 Consideration must also be given to protect children who engage in high risk behaviour which may cause serious self injury such as drug or substance misuse, running away, partaking in daring behaviour e.g. running in front of cars etc (all of which may indicate underlying behavioural or emotional difficulties or abuse).

### RESPONDING TO INCIDENTS OF DELIBERATE SELF HARM

- 9.20.5 It is good practice, whenever a child / young person is known to have deliberately harmed themselves, to undertake a multi-disciplinary risk assessment, along with an assessment of need.

## ADDITIONAL PROCEDURES

- 9.20.5 Any child reported to be self harming must be the subject of a comprehensive paediatric assessment which includes liaison with CAMHS to discuss the most appropriate treatment pathway.
- 9.20.6 In addition to the normal child protection procedures the following procedures may apply to specific situations.

### Child at school

- 9.20.7 All school personnel who come into contact with a child who is deliberately self harming should inform the school's designated senior person for child protection.
- 9.20.8 Information should also be passed to the school nurse who can liaise with the child's GP where necessary.
- 9.20.9 The school should make arrangements to interview the child and ascertain whether the difficulties presented can be resolved with her/him and their parents within the school environment or whether outside help from other professionals is required.

### Child presenting to another agency (e.g. Connexions, Youth Service, Voluntary Organisations)

- 9.20.10 Any practitioner or professional not identified in the previous section who identifies or suspects that a child or young person is deliberately self-harming should follow CAF procedures and protocols, undertaking an assessment and sharing information with the relevant agencies immediately. They should identify themselves as the lead professional and take responsibility for brokering access to appropriate services unless it is clear that another professional (e.g. a social worker) already has that responsibility and/or until the CAF process identifies an alternative lead professional. Referral to counselling provision should be offered where it is available.
- 9.20.11 When the assessment creates serious cause for concern an immediate referral should be made to CAMHS and/or CSF.
- 9.20.12 When the assessment does not indicate immediate danger the CAF should be completed and consideration given to whether to refer to CAMHS and/or CSF but in all cases consideration should be given to whether:
- There is evidence parents / carers are failing to protect the child from harm or failing to diminish risks of further attempts at harm
  - The child is exhibiting behaviour beyond the control of her/his parent / carer and continues to self harm or attempt suicide
  - The child is too young or has learning difficulties and is unable or does not give an explanation that is consistent with self harming

## ADDITIONAL PROCEDURES

- The child is being harmed or suspected of being harmed by another adult or child - this may include injury from a sibling or severe bullying by other children or situations when the child is a witness to or the subject of domestic violence
- There is significant concern that the child's family circumstances would continue to place them at risk of significant harm

### Child referred to a social work team

- 9.20.13 When deliberate self harm is suspected or known, the child should be medically assessed at the A&E department.
- 9.20.14 For cases when deliberate self harm has been reported but the child is not in immediate danger, an Initial Assessment should be undertaken to determine what course of action should follow. This will include consideration as to whether a referral to CAMHS is necessary and / or whether a s.47 enquiry should be initiated.
- 9.20.15 It is essential to be clear and prioritise the need for an urgent specialist assessment in young people who are an acute suicide risk. In all cases consideration should also be given to the factors in 9.20.12 above.

### Child referred to CAMHS

- 9.20.16 When deliberate self harm is suspected or known the child should be seen and assessed at the A&E department.
- 9.20.17 For cases where deliberate self harm has been reported but the child is not in immediate danger, consideration must be given to the need for a multi-agency assessment and specifically for a:
- Paediatric assessment
  - Referral to Children's Social Care if any of the criteria in 9.20.13 apply, or other concerns about the welfare of the child exist

### Child presenting to hospital

- 9.20.18 Any child presenting to hospital with deliberate self harm must be assessed by a paediatrician who will decide on treatment, admission and referral to CAMHS and Children's Social Care in consultation with the health care team.
- 9.20.19 Any child presenting to hospital with deliberate self harm as defined in section 9.20.1 should normally be referred to CAMHS and admitted to a children's ward overnight. When a young person has been assessed in A&E and has no thoughts or intent to commit suicide it may be appropriate to liaise with CAMHS and, following agreement with them, make a referral for an early out patient appointment in the local CAMHS clinic.

## ADDITIONAL PROCEDURES

- 9.20.20 A comprehensive discharge plan should be made which includes follow up appointments with relevant professionals.
- 9.20.21 If there are concerns about the welfare or safety of a child prior to discharge home a referral must be made to Children's Social Care who must be involved in the discharge planning arrangements.

## 9.21 SEXUAL EXPLOITATION

### DEFINITION

- 9.21.1 Sexual exploitation of children is child sexual abuse and often also involves physical and emotional abuse. Neglect may also be a feature of the child's care.
- 9.21.2 This form of abuse involves the exchange of sexual activities by children for commodities such as money, drink, drugs, shelter, protection, accommodation etc. It is often perpetrated by an adult through violence or threats of violence and may include the child's involvement in prostitution and abusive images, whether by printed materials, film / video, computerised image and the internet (see also procedures re abusive images of children & the internet [9.3](#)).
- 9.21.3 Sexual abuse involves the exploitation of both girls and boys under the age of eighteen and the children involved must be regarded as potential victims of abuse. Children do not make 'informed' choices to enter or remain in sexual exploitation, but may do so from coercion, enticement, manipulation or desperation.
- 9.21.4 This procedure should be read in conjunction with those covering underage sexual activity in [9.23](#).

### LEGAL POSITION

- 9.21.5 Prostitution is not of itself illegal, though there are offences that make selling or buying sexual services on a street or in a public place illegal.
- 9.21.6 Girls and boys under the age of sixteen cannot **lawfully** (though may in practice) consent to sexual intercourse. Anyone engaging in sexual activity (as defined in The Sexual Offences Act 2003) with a child under the age of sixteen is committing an offence. Children under thirteen years of age are presumed to be **incapable** of consent to sexual activity and specific offences, including rape, exist for child victims under this age.

## PRINCIPLES

- 9.21.7 The particular principles underpinning this area of work are that:
- Children and young people have a right to be protected from abuse and exploitation
  - Preventing child abuse requires effective inter-agency collaboration at all operational levels in protecting victims and in bringing to justice those believed to be responsible
  - Victims of abuse should be considered primarily under the provisions of the Children Act 1989, the child's welfare being paramount
  - Premature criminalisation of young people in these circumstances is to be avoided
  - Each child is unique and due consideration should be given to matters of gender, race, religion, culture, language and sexual orientation

## POLICY IMPLICATIONS

- 9.21.8 Young people who are identified as being vulnerable to any form of sexual exploitation are primarily 'in need' of support or services under s.17 Children Act 1989.
- 9.21.9 Child protection considerations arise when there are concerns about the care young people are likely to receive. This might include doubts about the adequacy of care, in terms of supervision or control.
- 9.21.10 In either of the above circumstances, inter-agency collaboration is required particularly at the investigation and assessment phase in agreeing action to be taken in individual cases, including:
- Invoking complex investigation procedures if a highly organised activity is being described ([see 9.16](#))
  - Invoking standard child protection procedures in appropriate circumstances whereby an early strategy discussion should be held
  - Providing immediate support and services to victims of crime and their families
  - Giving due consideration to diagnosis, treatment and management of sexually transmitted diseases, contraception advice, and obstetric care if indicated

### CONFIDENTIALITY

- 9.21.11 Ensuring a proper balance between maintaining a trusting relationship with young people and working in partnership with parents and others often poses dilemmas. Professionals working with children follow ethical principles of confidentiality under most circumstances. However it is important to convey via the professional relationship that absolute confidentiality cannot be guaranteed in all situations. It is the welfare of the child and other children potentially at risk that must remain paramount over all other considerations.
- 9.21.12 While it is important that children and young people are able to talk freely to staff about relationships and associated problems, it is sometimes necessary to share confidential information with significant others in protecting any child or other young person from harm and exploitation. These might include parents/carers, other child welfare professionals and the Police. This sometimes requires consultation with line managers and it may extend to seeking legal advice in particular circumstances.

### PROCEDURES

- 9.21.13 Individual cases of concern reported to the Police or to Children's Social Care will result in immediate exchange of information between those agencies in agreeing action to be taken in:
- Immediate protection of the child concerned;
  - Planning any further action to be taken as per these procedures
- 9.21.14 Where there is a clear need to protect a child from harm arising from the care they are likely to receive, existing child protection procedures will apply and consideration be given to her/his immediate protection.
- 9.21.15 Children who otherwise come to the attention of the Police should be returned to their current place of residence unless there are real concerns of their immediate protection. The use of Police powers under s.46 Children Act (Police Powers of Protection) may be considered in exceptional circumstances.
- 9.21.16 Children's Social Care contact points will be:
- The child's named social worker or local team
  - Residential staff or foster carers for those looked after
- 9.21.17 Health Service contact points will be the named child protection paediatrician and/or nurse.

## LOOKED AFTER CHILDREN

### Child placed in residential care

- 9.21.18 When a residential social worker suspects or knows of a child being sexually exploited s/he should inform her/his line manager. The child's Area social worker must also be informed.
- 9.21.19 The Area social worker will confirm with the team manager arrangements for an urgent strategy discussion or placement review according to whether there is suspicion or real concern.

### Child placed with a foster carer

- 9.21.20 The child's social worker and family placement team supervising social worker should discuss with the foster carer which of the steps expected of residential staff the foster carer can reasonably undertake, and how they might be reasonably expected to deal with the child's involvement in prostitution.
- 9.21.21 The staff involved with the foster carer will take steps to advise and support them in what is likely to be a very challenging and stressful situation.

### Strategy discussions and placement review meeting

- 9.21.22 The s.47 strategy discussion or placement review meeting must consider the additional factors:
- Risks to other children in placement
  - Whether the child should remain in placement
  - The feasibility of controlling the child's movements and the likely effects of doing so
- 9.21.23 Meetings must consider and record the appropriateness and method of informing the child's parent/s. If a child is 'accommodated', parent/s must be informed of all significant matters. If a child is subject to a Care Order, generally parent/s should be informed and the rationale for any decision not to inform them should be recorded on file.
- 9.21.24 Any strategy in the support plan that has implications for restriction of liberty or confiscation of property must have the written agreement of the service manager.
- 9.21.25 The support plan will form part of the care plan for the child and pathway plan in the case of care leavers.

## ADDITIONAL PROCEDURES

### Involvement of groups of looked after children

- 9.21.26 Where there is knowledge or suspicion that looked after children are involved together or being controlled by the same person there will need to be:
- Consideration of the need for the applicability of complex abuse procedures
  - Efforts made to ensure that strategy meetings and /or multi-agency planning meetings on different children result in consistent plans
  - Involvement of the Head of Child Protection or nominated representative

### HEALTH CARE CONSIDERATIONS

- 9.21.27 Children who engage in such high risk activities are also likely to neglect their own health care needs. Illness may be neglected, particularly menstrual infections and pregnancy.
- 9.21.28 Young people should be encouraged to take charge of their own health care needs and use health care resources appropriately. Their GP would usually be the appropriate starting point. Where appropriate, Community Paediatric Services, Family Planning Services and the Genito-urinary Medicine Clinic and / or nurse for looked after children can be accessed directly.

### DRUGS & SUBSTANCE ABUSE

- 9.21.29 There is strong association between illicit drug and alcohol abuse and sexual exploitation.
- 9.21.30 Further information and treatment options can be sought via the local multi agency Drug and Alcohol Teams (DATs).

### PERSONAL VIOLENCE

- 9.21.31 Children who are sexually exploited may have been subjected to abuse - both physical and sexual. There is often a reluctance to disclose this abuse. Self-destructive behaviours, including cutting, parasuicide, depression, guilt, sleep and appetite disorders should all raise suspicion of abuse. Specialist help should be sought to work with young people in these circumstances.

## 9.22 TRAFFICKING & EXPLOITATION

9.22.1 See 4.12.16 for definitions and risk indicators.

### SCOPE

9.22.2 This procedure has been developed to address concerns about the disappearance, following arrival in this country, of vulnerable children from abroad, by:

- Identifying and protecting those who may be at risk of significant harm through trafficking and exploitation
- Preventing their disappearance from care and accommodation by disrupting any organised activity to exploit children
- Sharing information with a view to tracing such children who have disappeared from care and accommodation

9.22.3 The procedure applies to both accompanied and unaccompanied children, including asylum seekers, for whom there are concerns about safety.

### PORT OF ENTRY

9.22.4 Hertfordshire does not have a port of entry.

9.22.5 Immigration officers undertake the identification of children at risk of harm. Children who do not meet the immigration criteria for entry and children, who, irrespective of their immigration status are believed to be at risk of harm if they are allowed entry, are referred to Children's Social Care. Records for these children exist both within Immigration and Nationality Directorate and with the receiving agency.

### CHILDREN ALREADY IN COUNTRY

9.22.6 Professionals should be familiar with the advice about migrant children in 4.12 and refer to Children's Social Care where there are concerns about such children including suspicions of trafficking concerning a particular child/ren victim, adult perpetrators or suspicious activity at specific addresses.

### REFERRAL & INITIAL INFORMATION GATHERING

9.22.7 Children's Social Care (Client Services) should obtain as much information as possible from the referrer, including the child's name, dob, address, name of carer/guardian, address if different, phone number, country of origin, home language and whether s/he speaks English, names of any siblings or other children.

## ADDITIONAL PROCEDURES

- 9.22.8 The referrer must be asked to put her/his concerns in writing and the social worker should verify, as soon as possible that the child is living at the address.
- 9.22.9 When a referral is made from a school or Children's Services (Education) the list of documentation provided at admission should be obtained.
- 9.22.10 A Home Office check should be completed to clarify status of the child/ren and the adult/s caring for them.

## ACTION AFTER INITIAL INFORMATION GATHERING

- 9.22.11 On completion of initial information gathering the social worker must discuss the referral with a Children's Social Care team manager to agree and plan next steps:
- No further action if no concerns are identified
  - An Initial Assessment to decide whether appropriate arrangements for the child have been made by her/his parents or there are grounds to accommodate the child or the child is in need of immediate protection and/or a s.47 enquiry should be initiated
  - There are grounds to accommodate the child (the child is lost or abandoned, there is no person with parental responsibility for the child, the person who has been accommodating the child is prevented, for whatever reason, from providing suitable accommodation or care)
  - Enough information at this stage to instigate a s.47 enquiry
  - Enough information at this stage to conclude the child is in need of immediate protection i.e. an Emergency Protection Order or Police Powers of Protection (in an emergency) and a s.47 enquiry initiated
- 9.22.12 The social worker should advise a professional referrer of the plan.
- 9.22.13 The social worker must check all documentation held by the referrer and other relevant agencies. Documentation should include, passport, Home Office papers, birth certificate, proof of guardianship. The list is not exhaustive and all avenues should be looked into.
- 9.22.14 When assessing paperwork / documentation attention should be given to detail e.g. when was passport issued, how long is the visa for, does the picture resemble the child, is the name in the passport the same as the alleged mother / father, if not, why not, does the documentation appear original (take copies to ensure further checks can be made).

### Assessment interview

- 9.22.15 Once all possible information has been gathered, the social worker, their line manager and the Police should decide whether to conduct joint interviews with the Police, and if to initiate a s.47 enquiry
- 9.22.16 If the family are visited, standard social work practice should be followed. The child should be seen alone, preferably in a safe environment and without carers in proximity.
- 9.22.17 In undertaking any assessment and all subsequent work with the child, a suitable interpreter must be used if required (see 9.12). The interpreter needs to be aware if there are concerns about trafficking and cultural advice sought.
- 9.22.18 Questions should explore the household composition, parents / carers' employment, tasks / work undertaken around the house or elsewhere, length of time in this country, where s/he lived and went to school in country of origin, who cared for her/him in country of origin.
- 9.22.19 The assessment needs to focus on **how and why the child arrived in the UK** and should try to establish:
- Family / household composition
  - Parent / carer's employment
  - Tasks / work undertaken in house and elsewhere
  - Length of time in this country
  - Where s/he lived and went to school previously, including in country of origin
  - Who cared for her/him in country of origin – and subsequently
  - If the family sent the child to the UK, or elsewhere
  - Did the child know where they were being sent and what is her/his understanding of why they are here
  - Was there a facilitator (someone who arranges the details in the country of origin)
  - Did the family pay the facilitator
  - Was the child prepared with information to provide if intercepted at the airport
  - Did anyone else travel with the child, and if so what happened to that person on arrival
  - Was the child to be met at any particular airport (note, the child may have been intercepted on transit)
  - What does the child want themselves
  - Has the child a mobile phone or a SIM card

## ADDITIONAL PROCEDURES

- Explore if the child knows anyone in the UK, or has phone number/s of friends / family (explain it is alright to know people and it may be in her/his interests to be reunited with a genuine family member)
  - Re-confirm why s/he came to the UK or left her/his country of origin
- 9.22.20 The assessment also needs to focus on the child's understanding of her/his situation and knowledge of trafficking. S/he should be provided with knowledge about trafficking, that it is a fundamental abuse of human rights and the possible dangers for the child.
- 9.22.21 The adults in the family / household should be interviewed (separately if possible) on the same basis, establishing the same information, so that a comparison can then be made between the answers to ensure they match.
- 9.22.22 All documentation should be seen and checked. This includes Home Office documentation, passports, visas, utility bills, tenancy agreements and birth certificates. Particular attention should be given to the documentation that had been presented to the school at point of admission.
- 9.22.23 This interview should be conducted as fully and completely as possible, to ensure accuracy and to avoid intrusion on the family over a longer period than is absolutely necessary.
- 9.22.24 On completion of the assessment the social worker, Children's Social Care team manager, CAIU, referring agency and other professionals as appropriate should discuss and agree future action, usually at a meeting (if there are grounds to accommodate the child, take immediate action or initiate a s.47 enquiry these should not be delayed until a meeting is held).
- 9.22.25 Where it is found the child is not a family member and is not related to any other person in this country, consideration should be given to establishing status and assisting the child as an unaccompanied minor.
- 9.22.26 Any action regarding fraud, trafficking, deception and illegal entry to this country is the remit of the Police and the Home Office. The local authority should assist in any way possible.

### S.47 ENQUIRY

- 9.22.27 Whenever a practitioner or volunteer becomes concerned that a child is at risk of significant harm, a referral must be made to Children's Social Care and the local Police CAIU in accordance with procedures in modules 6 & 7 of this manual.

## ADDITIONAL PROCEDURES

- 9.22.28 If the concern is raised at a port of entry, immigration service should without delay, contact the local Children's Social Care and CAIU. If the child is already in the UK, the referral must be made to the Children's Social Care and CAIU for where the child resides.
- 9.22.29 Strategy discussions should be held in accordance with 6.7. This is a complex form of abuse and a meeting will be required to plan the enquiry **as soon as possible**. The meeting must
- Develop a strategy for making enquiries into the child's circumstances, including consideration of a video interview if the case is likely to go to court
  - Develop a plan for the child's immediate protection, including the supervision and monitoring of arrangements (for looked after children this will form part of the care plan);
  - Agree what information can be given about the child to any enquirers and
  - Agree what support the child requires

## LOOKED AFTER CHILDREN (WHO ARE AT RISK OF BEING TRAFFICKED)

- 9.22.30 The social worker should seek a placement proportionate to the need to protect the child. This may include protection from possible abduction and in some cases require surveillance cameras in operation, monitoring of phone calls and intensive supervision. If required an escort must be organised to take the child there.
- 9.22.31 Location of the child must not be divulged to any enquirers until they have been interviewed by a social worker and their identity and relationship / connection with the child established, with the help of Police and immigration services, if required.
- 9.22.32 A care plan should be agreed, as for all looked after children, involving the child, the social worker, carers and Police. This should address:
- Explicit risk factors
  - Completion of a Core Assessment if one has not already been undertaken
  - Supervision and monitoring arrangements
  - Care planning meetings and LAC reviews
- 9.22.33 The Core Assessment of the child's needs must be undertaken immediately to include:
- Establishing relevant information about the child's background
  - Understanding why s/he has come to the UK (needs-led v her/his right to enter the country) and
  - Assessing vulnerability to continuing influence / control of traffickers

## ADDITIONAL PROCEDURES

- 9.22.34 Planning and actions to support the child must minimise the risk of the traffickers re-involving a child in exploitative activities. Thus:
- Foster carers / residential workers should have information about how to provide intensive supervision and must be vigilant about anything unusual e.g. waiting cars outside premises and phone enquiries.
  - The social worker must immediately pass to the Police any information on the child (concerning risks to her/his safety or any other aspect of the law pertaining to child protection or immigration or other matters), which emerges during the placement
  - The child's social worker must try to make contact with the child's parents in the country of origin (immigration services may be able to help), to find out the plans they have made for their child and to seek their views - the social worker must take steps to verify the relationship between the child and those thought to be her/his parent/s; see appendix 1 for sources of contact information
- 9.22.35 Anyone approaching the local authority and claiming to be a potential carer, friend, member of the family etc, should be investigated by the social worker, Police and immigration service. If the Children's Social Care team manager is satisfied that all agencies have completed satisfactory identification checks and risk assessments the child may transfer to their care.
- 9.22.36 The child will be subject to regular LAC reviews. At the conclusion of the child protection enquiry and at each review a decision is to be made as to whether s/he continues to be at risk of being trafficked and the reasons for this decision recorded.
- 9.22.37 Should it become clear the risk of trafficking is extreme and immediate, consideration must be given to commencement of legal proceedings, in conjunction with the service manager and legal adviser.
- 9.22.38 Should it become clear that the child is not at risk of trafficking, or that the risk has been reduced, the continued appropriateness of the safe placement should be considered and efforts made to identify family or friends who can appropriately take over the care of the child/young person. In order to promote stability children should not usually be moved to another placement, but their supervision reduced.

## ISSUES FOR PROFESSIONALS TO CONSIDER WHEN WORKING WITH TRAFFICKED & EXPLOITED CHILDREN

- 9.22.39 Children who have been trafficked and exploited are likely to need some of the following services:
- Appropriately trained interpreting
  - Someone to spend time with them and build up a level of trust

## ADDITIONAL PROCEDURES

- Counselling via CAMHS
- Independent legal advice about their rights and immigration status
- Their whereabouts to be kept confidential
- Discretion and caution to be used in tracing their families;
- A risk assessment to be made of the danger they face if repatriated: trafficked and exploited children who eventually return home can suffer discrimination, particularly those who have been sexually exploited
- To be interviewed separately - children do not speak openly until they feel comfortable
- Medical services (including, for victims of torture)
- Education

9.22.40 Attempting to persuade a child victim to testify against a trafficker is complicated. The child usually fears reprisal from the traffickers and/or the adults whom the child was living with in the UK if they co-operate with the Police. This includes reprisals against their family in their home country.

9.22.41 Children, who might agree to testify, fear that they will be discredited because they were coerced into lying on their visa applications / immigration papers.

## MISSING CHILDREN AT RISK OF BEING TRAFFICKED

9.22.42 If a child, who is at risk of being trafficked, goes missing, residential staff / foster carers must immediately inform Children's Social Care the social worker, Children's Social Care team manager or Emergency Duty Team, who must contact the Police control room and Immigration Service.

9.22.43 The Police will complete a MISPER form, and notify the National Missing Persons' help-line. In all cases the Police must update Children's Social Care with the progress of the investigation.

9.22.44 Procedures for missing children must be instituted (see [9.14](#))

## 9.23 UNDERAGE SEXUAL ACTIVITY

### INTRODUCTION

9.23.1 Nationally 26% of women and 30% of men report that they had sexual intercourse by the age of 16 (Wellings et al 2001). All young people have a right to confidential advice from professionals about sexual health/ sexually transmitted diseases, contraception and relationships.

## ADDITIONAL PROCEDURES

- 9.23.2 The purpose of these procedures is to clarify the process / responsibilities of practitioners with regards to assessing the risks and identify cause for concern in under age sexually active young people.

## LAW

- 9.23.3 The minimum age at which young people of either gender and whatever sexual orientation can consent to have **lawful** sexual intercourse, is sixteen years of age,.
- 9.23.4 With respect to a child under the age of 13, her/his actual consent to any sexual activity is irrelevant because **the law presumes s/he is incapable of informed consent**. Under the Sexual Offences Act 2003, rape or assault by penetration of a child under thirteen may attract a sentence of imprisonment for life.
- 9.23.5 The Sexual Offences Act 2003 makes provision for young people of less than sixteen years old, to be offered confidential professional advice on contraception, condoms, pregnancy and abortion.
- 9.23.6 A person is not guilty of aiding, abetting or counselling a sexual offence against a child where s/he is acting for the purpose of:
- Protecting a child from pregnancy or sexually transmitted infection
  - Protecting the physical safety of a child
  - Promoting a child's emotional well-being by the giving of advice
- 9.23.7 This exception, in statute, covers not only health professionals, but also anyone who acts to protect a child, for example teachers, school nurses, Connexions personal advisers, YOT officers, youth workers, social workers and parents.

## CONFIDENTIALITY

- 9.23.8 The duty of confidentiality owed to a person under 16 in any setting is the same as that owed to any other person, but the right to confidentiality is not absolute.
- 9.23.9 Where there is a serious child protection risk to the health, safety or welfare of a child or others this outweighs her/his right to privacy. In these circumstances professionals should act in accordance with modules 3, 4 and 5.
- 9.23.10 Research and experience have shown repeatedly that keeping children safe from harm requires professionals and others to share information. Such information sharing must be in accordance with legal requirements and professional guidance (see module 2).

## RISK ASSESSMENT

- 9.23.11 All children, regardless of gender or sexual orientation, who are believed to be engaged in or planning to be engaged in, sexual activity must have their needs for health education, support and/or protection assessed by the agency involved.
- 9.23.12 This assessment must be carried out in accordance with the child protection procedures within this manual and professional / agency guidance.
- 9.23.13 In assessing the nature of any particular behaviour, it is essential to look at the facts of the actual relationship between those involved.
- 9.23.14 The following non exhaustive considerations must be taken into account in assessing the extent to which the child (or other children) may be suffering or at risk of harm:
- The age of the child: the younger the child the stronger the presumption must be that sexual activity is a matter of concern
  - The level of maturity and understanding of the child and her / his competence to understand and consent to sexual activity
  - Power imbalances, including through age and development: size, gender, sexuality, levels of sexual knowledge, learning ability
  - Power imbalance where sexual partner in position of trust or authority
  - Where a young person has a learning disability or communication difficulty that could hinder their capacity to disclose that they have been abused
  - Use of overt aggression, coercion or bribery
  - Use of alcohol and / or drugs were to facilitate the activity
  - If the young person's own behaviour e.g. the use of drugs, means s/he is unable to make an informed choice
  - Any attempts to secure secrecy by the sexual partner beyond what is usual in teenage relationships e.g. his/her identity being a secret
  - If the sexual partner is known by agencies to have concerning relationships with other young people
  - If the young person denies or minimises adult concerns
  - Presence of a sexually transmitted infection in a very young person
  - If the relationship involves behaviours considered to be 'grooming' in the context of sexual exploitation
  - Where sex has been used to gain favours, e.g. cigarettes, clothes, CDs, trainers, alcohol, drugs etc
  - Where the young person has a lot of money or other valuable things which cannot be accounted for

## ADDITIONAL PROCEDURES

- Knowledge about the child's circumstances / background, including any familial child sex offences
  - The child's behaviour e.g. withdrawn, anxious
- 9.23.15 If there are concerns relating to any of the above factors, these should be discussed with the young person and s/he should be informed that you will need to seek advice.
- 9.23.16 Throughout the risk assessment process the young person should be offered treatment and advice if they are considered competent to understand the treatment proposed (Fraser competent assessment).
- 9.23.17 Where a risk assessment on a **child aged fourteen to fifteen** years is satisfactory the practitioner can use her/his professional judgement as to what advice and support is needed.
- 9.23.18 Where a **child is aged thirteen to fourteen years** of age the practitioner should discuss the issue with her/his child protection lead. If the advice is to refer to Children's Social Care the child should be informed of this.
- 9.23.19 **Children under thirteen** do not under any circumstances have the legal capacity to consent to sexual activity. A sexually active child of twelve years and under should be offered the appropriate advice and support needed to protect them but advised that a referral will be made to Children's Social Care who will have a strategy discussion with the Police CAIU as to what further action should be taken.

## 9.24 UNEXPECTED DEATH OF A CHILD

- 9.24.1 Regulation 6 of the LSCB Regulations 2006 (SI 2006 No. 90) indicates that the duty to provide a co-ordinated response by the local authority and its board partners and other relevant persons to an 'unexpected death' of a child (as well as the child death review function for all child deaths) applies with effect from 01.04.08.
- 9.24.2 **When, in the light of further discussions and levels of available resourcing, new procedures are agreed, they will appear in the updated version of these procedures scheduled for 2008.**
- 9.24.3 **Pending the development of such procedures, the current Sudden Unexpected Death in Infancy (SUDI) guidance should be followed (see [www.hertsdirect.org/safeguarding](http://www.hertsdirect.org/safeguarding) )**