



# **Plymouth Safeguarding Children Board**

## **(Child Protection Handbook Additional Local Plymouth Guidance)**

**Version No v3.1**

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### **INTRODUCTION**

During 2007, Plymouth Safeguarding Children Board became part of the South West Peninsula Group, which adopted Web based Child Protection Policy and Procedures. These Procedures are reviewed on a regular basis and revisions posted on the web site.

Please go to: [www.swcpp.org.uk](http://www.swcpp.org.uk)

These web based procedures give multi agency direction, on how staff should manage child protection queries.

Some further local guidance has been requested from agencies in Plymouth, it is with this in mind that this guidance has been produced. This guidance will be put onto the PSCB Web Site shortly, it is planned that this will be available summer 2008.

**Plymouth Safeguarding Children Board can be found at:**  
[www.plymouth.gov.uk/localsafeguardingchildrenboard.htm](http://www.plymouth.gov.uk/localsafeguardingchildrenboard.htm)

March 2008

# Plymouth Safeguarding Children Board

## (Child Protection Handbook Additional Local Plymouth Guidance)

Jointly approved by Plymouth Safeguarding Children Board, July 2008.

This local guidance fits with the National Framework for Safeguarding Children, including:

### **Legislation**

The Children Acts, 1989 and 2004, and the Safeguarding elements from any other Act:

- Education
- Health
- Housing
- Criminal Justice
- Sexual Offences
- Adoption
- Domestic Violence
- Data Protection

### **Statutory Guidance**

Working Together to Safeguard Children 2006 and  
The National Service Framework, including:

- Every Child Matters and any other Government guidance, impacting on safeguarding children

## **“Safeguarding Children is everyone’s responsibility”**

*(s11 Children Act 2004 guidance and s175 Education Act 2002)*

### **Good Practice**

Information from Plymouth Safeguarding Children Board (PSCB), Serious Case Reviews, highlights the need for Professionals to keep their focus on the child and the key elements, which contribute to ensuring the child’s safety.

With that in mind, the PSCB Serious Case Review sub group and Policy and Procedures sub group have draw up this brief “checklist”, for professionals working with children and families, where they may be a child protection concern.

# Plymouth Safeguarding Children Board

## Safeguarding Children Good Practice Checklist

- Have you been able to speak to the child alone?
- Can you still speak to the child alone?
- Where will the child be, for the next 24 hours?
- Is there an immediate risk of harm to the child?
- Do you have the information about the child and family?
- Have you completed the Common Assessment Framework, or equivalent?
- Are other children at risk of harm?
- Is the mother at risk of harm?
- Do you consider it safe to discuss the concerns with the parents?
- Will the child/young person resist efforts to safeguard them (drugs/coercion)?
- Have you recorded, clearly and promptly everything said by:
  1. The child
  2. Parents
  3. Family
  4. Professionals
- Have you recorded, clearly and promptly everything you have said to:
  1. The child
  2. Parents
  3. Family
  4. Professionals
- Is there any disagreement about non-accidental injuries between professionals? If so please refer to the “Resolving Professional Differences” Procedure.
- Have you complied with the current Child Protection Procedures?
- Is there a need to inform Police, because a crime has been committed?

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## The Nature of Child Abuse

### General

- 1.1 The following sets out what is meant by child abuse and neglect and their possible impact on a child. It also sets out some of the signs and symptoms that may give cause for concern. The list is not exhaustive and signs and symptoms of one type of abuse may also be found in the other types of abuse.
- 1.2 Identification of child abuse is difficult and will normally require both social and medical assessment. It must always be considered that alternative social or medical explanations may exist for the problem. There may also be considerable overlap of one category of abuse with another.
- 1.3 The sustained abuse of children physically, emotionally, sexually or by neglect can have major long-term effects on all aspects of a child's health, development and well-being. Sustained abuse is likely to have a deep impact on the child's self image and self-esteem and on their future life as an adult.
- 1.4 Any potential abusive incident has to be seen in context to assess the extent of harm to a child and appropriate intervention. A number of factors may serve to increase the likelihood or level of actual significant harm thereby increasing concern and the possible need for intervention.
- 1.5 An assessment of the child and family will help to establish the impact. Relevant factors will include:
  - Child's means of coping and adapting
  - Support from the family and social network
  - Impact of intervention
  - Quality of the family environment
  - Subsequent outcomes
- 1.6 Child abuse on a child can be inflicted by a physical response such as physical, sexual assaults or by failing to act to prevent harm such as neglect. Harm can also be inflicted emotionally. Abuse can be inflicted by the commission or omission of an act and can occur in family, institutional or community settings by those known to them or by strangers.
- 1.7 Children exposed to abuse may also have been exposed to domestic violence and consequently a discontinuity of care. Prolonged and / or regular exposure to domestic violence can have a serious impact on a child's development and emotional well-being including a threat to an unborn child, physical assault as a result of a child's intervention between the adult participants, emotional distress and substance misuse which can be neglectful.

## Physical Abuse

- 2.1 Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after (See Munchausen Syndrome by proxy).
- 2.2 Most injuries to children occur accidentally and can be explained simply. Injuries that are not explained adequately by the child or carers or are not consistent with that explanation may indicate abuse.
- 2.3 In young children, especially babies, crying due to internal injuries such as fracture or bleeding may initially be mistaken for other causes of distress, especially when there are no external signs of trauma.
- 2.4 The following are some of the signs that may indicate abuse:
  - Bruising to the face (other than forehead) especially cheeks, eyes, ears, mouth
  - Bleeding from the mouth or ears
  - Bruising around the neck (including petechial or pinpoint red bruising)
  - Bruising in pattern suggestive of finger or handprint, or of implement mark such as stick or belt
  - Bite marks especially of adult size
  - Multiple bruising of different ages (more than expected for stage of child's development)
  - Burns and scalds, especially cigarette burns or burn injuries with inadequate or inconsistent explanation and which are recurrent. Some may have defined lines to the scald
  - Fractures especially of a child under 2 years
  - Loss of consciousness, apnoeic attacks or fits when other causes eliminated
  - Poisoning, including prescribed or illicit drugs, alcohol, household substances
  - Sudden Infant Death Syndrome (needs sympathetic exploration)
  - Fabrication or suggestion of symptoms, tampering with test results, or inducing illness (Munchausen Syndrome by proxy)
  - Bruising to the sexual areas (may indicate sexual abuse)
  - Round red burns on soft, tender, non-protruding parts of the body such as inside the mouth, inside of legs, behind the knees, inside the arms and on genitals
  - Torn frenulum (upper mouth) in babies could be result of rough handling or physical assault
  - Admission of punishment that appears excessive
  - Fear of undressing for example P.E. at school
  - Fear of medical intervention
  - Absence from school

## Sexual Abuse

- 3.1 Whilst there are many signs that have been associated with sexual abuse, some of these have been also associated with medical or emotional problems. It is therefore important that when there are worries about a child's behaviour, which cannot be explained satisfactorily, sexual abuse should be borne in mind as a possible explanation.
- 3.2 Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative acts or nonpenetrative acts. It may include non-contact activities, such as involving children looking at, or participating in the production of, pornographic material or watching sexual activity, or encouraging children to behave in sexually inappropriate ways.
- 3.3 Disturbed behaviour including self-harm, inappropriate sexual behaviour, sadness, depression and loss of self-esteem have all been linked to sexual abuse. The severity of impact is likely to increase the longer it goes on.
- 3.4 The extent of premeditation, the degree of threat and coercion, sadism and bizarre or unusual acts may add to the severity of impact.
- 3.5 Once the sexual abuse is recognized or disclosed the child's ability to cope will very much depend on the support that a non abusing carer gives in respect of understanding, help and protection.
- 3.6 Sexually abused children are frequently obedient to adults and anxious to please but have poor peer group relationships. Many are asymptomatic, particularly in the younger age range.
- 3.7 The following are some of the signs that may indicate abuse:
  - Genital or anal lacerations, bleeding or trauma
  - Genital or peri-anal inflammation or irritation
  - Persistent or recurrent vaginal discharge
  - Sexually transmitted disease including warts
  - Pregnancy
  - Recurrent urinary infections or cystitis
  - Secondary enuresis or encopresis (wetting or soiling)
  - Recurrent unexplained abdominal pain
  - In younger children - overt sexualised behaviour, compulsive masturbation, acting-out and aggressive behaviour, drawing or play activities that are sexually explicit
  - In older children - withdrawn and / or overtly compliant behaviour, depression and suicidal behaviour, self-mutilation, running away, school truancy, substance abuse
  - Any age - sudden change in normal behaviour or sexual awareness and knowledge advanced for years of development
  - Known prostitution
  - Unexplained gifts or money

- Refusing to stay with certain persons or unhappy at being looked-after by certain persons.
- 3.8 Children who are being sexually abused do not necessarily display any behavioural disturbance. They may also show other signs such as physical abuse.

## Neglect

- 4.1 Neglect is the persistent failure to meet a child's basic physical and / or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.
- 4.2 Severe neglect of young children is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development and long-term difficulties with social functioning, relationships and educational progress.
- 4.3 In extreme cases neglect can lead to death.
- 4.4 Children require the provision of care to be consistent and appropriate to the age of the child, their understanding and their development. Failure to meet the basic needs over a period of time, or failure to ensure access to appropriate medical treatment may result in a range of symptoms.
- 4.5 The following are some of the signs that may indicate neglect:
- Failure to thrive where medical investigation has excluded any medical reason
  - Disturbance of appetite including reluctance to feed, gorging food or stealing food
  - Poor skin care, hair loss or poor condition, cold red hands and feet
  - Poor hygiene
  - Inadequate clothing for the time of year
  - Lack of appropriate supervision leading to risk of accidental injury
  - Developmental delay, impaired language skills, poor social skills, apathetic or dejected presentation
  - Persistent failure to seek or to follow necessary medical advice or treatment
  - Poor/ non-school attendance, poor academic attainment
  - Dirty, smelly and always hungry
  - Abandonment or desertion
  - Left alone without appropriate supervision especially at an early age
  - Unhygienic home conditions
  - Poor relationships with peers, but attention seeking from adults.

## Emotional Abuse

- 5.1 There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on developing a child's mental health, behaviour and self-esteem.
- 5.2 It can be especially damaging in infancy.
- 5.3 Underlying emotional abuse is as important as other more visible forms of abuse in terms of its impact on a child. The extent of emotional abuse will need to be judged in respect of the context in which abuse is occurring and may be influenced by family environment and subsequent life events.
- 5.4 Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to the child that they are worthless or unloved, inadequate or valued only so far as they meet the needs of another person.
- 5.5 It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of a child. Some level of abuse is involved in all types of ill treatment of a child, though it may be present on its own.
- 5.6 The following may indicate some of the signs of emotional abuse:
  - Continuous withholding of approval and affection by the parent / carer
  - Discipline that is severe and inappropriate or which is non-existent with few or no boundaries set
  - Exploitation by the parents/carer to fulfil their needs.
  - Impaired ability for play and enjoyment
  - Lack of curiosity and natural exploration, air of detachment
  - Persistent head banging or rocking in a younger child
  - Delayed social and language skills
  - Low self-esteem, feeling of worthlessness
  - Eating disturbances, poor growth
  - Family history of domestic violence, mental illness of a carer or substance misuse
  - Behavioural difficulties including aggression and disruptive behaviour
  - Enuresis and encopresis (wetting and soiling)
  - Self-harm, overdose or attempted suicide.
  - Fear of new situations
  - Inappropriate emotional responses to painful situations
  - Social isolation from friends
  - Constant frozen watchfulness
  - Pseudo mature or explicit sexual behaviour

- Open masturbation or aggressive sex play with peers
- Only happy at school or kept away
- Stomach pains without medical explanation

5.7 It must be remembered that emotional abuse will also be an element of other forms of ill-treatment of a child as well as occurring alone.

## Alleged Abuse of a Child from another Local Authority Area who is Residing in Plymouth Local Authority

### Introduction

- 1.1 Under Section 47 of the Children Act 1989 it is the responsibility of the Local Authority in which the child is at the time the abuse takes place to undertake child protection enquiries.
- 1.2 An allegation or incident of child abuse may involve children in the same placement (child-to-child abuse) or it may concern an allegation of abuse against a member of staff in a residential establishment or foster home or in other areas of the child's life (eg school).
- 1.3 The following procedures apply where a child from another Local Authority or from another County is residing in a home or establishment that is not directly managed by, and / or is the responsibility Plymouth Authority.
- 1.4 In particular, they apply to children who are 'looked-after' by another Local Authority and are residing in Plymouth either in a placement provided by that authority or have been placed by the same authority in an independent home or establishment within those areas. This could include a child placed in a residential children's home or in a foster home managed by an independent foster care agency.
- 1.5 Any member of staff who receives an allegation of abuse should follow the section 'Referral and Investigation'.

#### Action to be taken in Respect of a Child Looked-after in a Residential Establishment

- 2.1 An allegation or incident of child abuse must be reported to the Manager or Owner of the residential establishment unless the allegation is made against the manager or owner of the establishment.
- 2.2 If the allegation is against the Manager or Owner of the establishment then the member of staff aware of the allegation should contact the Advice and Assessment Service.
- 2.3 If the allegation needs further investigation then the appropriate course of action should include:
  - Ensuring the child receives immediate medical attention without further delay. If immediate medical attention is not required, but there is a need to record injuries, the duty Social Worker will advise as to the arrangements that will need to be made.
  - Procedures laid down for all Section 47 child protection enquiries should be followed which will include consultation with the local Police Child Protection Team.

- Consulting the Local Authority that has responsibility for the child. In particular the child's Social Worker/Line Manager must ensure that the child's parents are informed of the allegations.
  - A written agreement between the Local Authority Plymouth Authority as to which authority accepts responsibility for the subsequent action should be considered.
  - Ensuring that the manager of the residential establishment informs the Inspection and Registration Unit of the allegation.
- 2.4 The Head of Children's Services Social Services will ensure that a Strategy Meeting is convened to discuss the allegations of professional abuse or child-to-child abuse. This meeting should take place as soon as possible, bearing in mind the nature and seriousness of the allegations being made. In any event, the meeting should be convened within five working days of the information coming to hand.
- 2.5 The Advice and Assessment Social Worker should inform the Child Protection Co-ordinator for the area in which the child normally resides.
- 2.6 The procedure for the Strategy Meeting and who should attend can be found under the section 'Special Considerations - Re: Abusers'.
- 2.7 In addition to the standard membership of the meeting the child's Social Worker and / or Line Manager should attend wherever possible as well as the manager of the residential establishment unless the allegations have been made against them.
- 2.8 The Strategy Meeting will need to address in addition to the normal issues:
- Which professionals will take responsibility for the different elements of the investigation
  - What the co-ordinating role will be of the Local Authority in which the child lives in relation to the child protection enquiries, any possible criminal investigation and any disciplinary action
  - Whether the Local Authority that has placed the child at the residential establishment should be informed of the ongoing investigations and outcome

### **Action to be taken in Respect of a Child Looked-after in a Foster Home**

- 3.1 An allegation or incident of child abuse in respect of a child in a foster home managed by an Independent Foster care agency should be reported to the Foster Care Service Manager for the area in which the child is residing. They should take responsibility for informing the manager of the Independent Foster Care agency.
- 3.2 The procedures from 2.5 should be followed. However, the Strategy Meeting should be arranged by the local Administrative Assistant (Child Protection) and chaired by the Independent Chair Child Protection for the area in which the child resides.
- 3.3 Further advice is given in the section on 'Special considerations re abusers'.

## Action to be taken in Respect of a Child Temporarily Resident in Devon, Torbay or Plymouth but Not Looked-after

- 4.1 Similar procedures apply as outlined although it is likely that the child will not have a Social Worker in their home area. The Social Services department in the home Local Authority should be notified of the concerns in case they have any relevant information and also to provide the necessary support and advice to the child and parents if that appears to be appropriate.

## Children and Young People who Sexually Abuse Others

### Aim

- 1.1 An accountable approach to protecting the public and reducing the incidence of future victims, whilst at the same time dealing with children in a sensitive and consistent way, that will maximise the opportunity to effectively challenge, change and control their sexually abusive behaviour and also meet their other needs.
- 1.2 This protocol recognises that:
  - Children who sexually abuse others, differ significantly from adults who have committed sexual offences.
  - A multi agency approach should be systematic, consistent, co-operative and fair.
  - Multi-agency assessments of the child should take place before any care plans are made.
  - There may be times when the child has to come before the Criminal Justice System.
  - Intervention is aimed to minimise the risks posed by the child to themselves and others.

### Legislation/Guidance

- 2.1 The following is legislation and guidance in respect of this protocol:
  - Sexual Offenders Act 1997 (Cautioned/Convicted Schedule 1 Offender's including children need to register with Police - this can be imposed on parents).
  - Crime and Disorder Act (CDA) 1998 - Reprimand and Final Warnings, Prosecution and Court Orders.
  - Working Together to Safeguard Children Process.
- 3.1 The following process will occur:
  - All allegations that a child has committed a sexually abusive act should be reported to Advice and Assessment Service/Police.
  - This should be followed by an Initial Assessment and then by a Case-Planning meeting.
  - The meeting should contain members from Advice and Assessment Service; Police; Child and their Carer or significant others who have relevant information.
  - The meeting will seek to understand the initial assessment of the seriousness and risk posed by the child.
  - Agreement will be sought about the need for a full risk assessment and the time it will take, at the meeting.
  - After the risk assessment has been completed a further meeting will decide what further action is required, for example a core assessment which will ensure that their needs are assessed, along with any risks associated.

## Research Indicators

- 4.1 Research with adult sexual abusers indicates that many began committing sexually abusive acts during childhood or adolescence. They report that they 'grow into' rather than 'grow out' of their sexually abusive pattern of behaviour. Therefore, it is essential that sexually abusive behaviour by children and young people is treated seriously and given the same importance as any other form of alleged abuse.
- 4.2 Early intervention with children who sexually abuse others plays an important part in protecting the public by preventing the continuation or escalation of abusive behaviour. The chances of changing or controlling the child's behaviour is higher when they are still developing their identities and their behaviour is not yet established.
- 4.3 A significant number of adult sexual offenders were subjected to abuse and disruption in their lives. Evidence also suggests that children who sexually abuse others may have been exposed to violence within the family; witnessed or been subject to physical, emotional or sexual abuse; have problems in their educational development; and may have committed other offences. Consequently, work with children and young people who sexually abuse others must recognise that they are likely to be children in need and some in addition will be suffering or at risk of significant harm, and may, themselves, be in need of protection.
- 4.4 Children who sexually abuse others should be held responsible for their sexual abuse whilst being identified and responded to in a way that meets their needs as well as protecting others. Allegations of sexual abuse by another child must always be subject of a referral to the relevant child protection agencies.

## Key Principles

- 5.1 Work with children who sexually abuse others should be guided by:
  - A co-ordinated approach on the part of Youth Justice, Child Welfare, Education (including Educational Psychology) and Health (including Child and Adolescent Mental Health) Agencies.
  - The needs of children and young people who abuse others should be considered separately from the needs of their victims.
  - Completion of an assessment in each case, which covers both current developmental needs and specific needs arising from their behaviour.
  - An assessment should be carried out in each case, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour.
- 5.2 Neither Child Welfare nor Criminal Justice agencies should embark upon a course of action that has implications for the other without appropriate consultation. Where a child is already known to statutory organisations, the responsible workers must be contacted so consultation can take place regarding the appropriate course of action.

## Appendix A

1. The relationship between the alleged sexual abuser and the victim needs close examination. Sexual abuse is located within the misuse of power, control and authority. Some power differentials that need considering are:
  - Age
  - Gender
  - Race and culture
  - Physical strength and size
  - Physical presence (popularity versus isolation)
  - Differing cognitive functioning
  - Invested authority (prefect, babysitter, older sibling)
  - Self-image differences
2. Consent is often confused with compliance or co-operation. The key elements of consent are that there is:
  - An understanding of the proposal
  - Active not passive choice (just going along)
  - An equal power relationship
  - An absence of cajoling, coercion or force
  - An understanding of the consequences of the behaviour
  - Knowledge that any decision will be respected
3. Consideration should also be given to the:
  - Sophistication of the sexual interaction
  - Behaviour being age appropriate
  - Persistence and frequency of the behaviour
  - Evidence of pre-planning (grooming)
  - Pattern of the behaviour and any changes
  - Act being accompanied by bribery or aggression (no matter how subtle)
  - Attempts made by the child to secure the victims silence
  - Way the incident was disclosed/discovered

## Referral

- 6.1 It can be difficult to differentiate between sexually abusive behaviour and what is considered normal sexual exploration. Appendix A after paragraph 8.8 offers some indicators that could raise concerns and lead to a more detailed examination of the situation.

## Initial Assessment

- 7.1 Where the sexual abuse is of a serious nature or committed by a child over 10 years of age, immediate referral to Advice and Assessment Service, Children's Services and the Police should be undertaken. This is important because criminal investigations must not be compromised and compliment the overall approach to the situation.

## Children who experience Domestic Violence

### General

This guidance is intended for all professionals who work with children and their families, both in statutory and voluntary sectors.

### Definition

Different organisations have adopted different definitions of Domestic Violence.

For the purposes of this guidance, the following definition has been used:

‘Domestic Violence is any violent or abusive behaviour (whether physical, sexual, psychological, emotional, financial, verbal etc) which is used by one person to control and dominate another with whom they have or have had an intimate relationship’

(From: ‘Making an Impact’, a reader by Marianne Hester, Chris Pearson and Nicola Harwin 1998.)

### What is Domestic Violence

Domestic Violence can be expressed in a number of ways. It is very common for there to be more than one form of abuse occurring and it is likely to have been going on for some time. It can have physical, emotional, psychological and social consequences, which in turn may impact on a parent’s ability to offer care to their children. The lists given below are indicators of what domestic violence may involve and the potential consequences. However, these are not definitive and in any one family there may be any combination of a number of factors.

Domestic violence can include:

- Physical injuries, including bruising, broken bones, internal injuries, etc
- Sexual violence, including rape
- Verbal abuse, name calling and threats of violence
- Withholding financial support
- Controlling independence and choice
- Denial of physical freedom
- Threats of being returned to country of origin or deportation
- Threats that the children will be removed
- Threats of referral to mental health services
- Blaming the woman for everything that is ‘wrong’
- A process of being humiliated and undermined both individually and as a parent
- Isolation from family, friends and community
- Using pregnancy as a means of control

As a consequence of ongoing violence:

- Violence often escalates during pregnancy
- Children may be conceived as a result of rape

## The Impact on Children

The effects may be different for each child in the family and where possible, it is necessary to understand the child's experiences directly from themselves. This means seeing the children individually, on their own and being sensitive, discreet and reassuring, whilst bearing in mind issues of potential risk of significant harm.

The following gives an indication of the range of effects upon children. However, it is not an exhaustive list, and it is important to remember that every child responds to experiences in their own unique way.

- Physical injuries, including bruises, broken bones
- Being protective of mother and / or siblings; attempting to intervene either physically or in other ways
- Aggressive behaviour and demonstrations of anger
- Changes in behaviour / unpredictable behaviour
- Introversion / withdrawal
- Advance maturity sense of responsibility for parent and / or siblings, an 'old head on young shoulders'
- Feelings of guilt and blame
- Secretive / silent / not able to tell
- Fear / insecurity / emotional confusion
- Truancy from school / running away from home
- Disruptions in schooling and living arrangements
- Bed-wetting / nightmares / sleep disturbance which affect daytime behaviour eg tiredness in school
- Eating difficulties / self-harm / weight loss
- Sadness/depression/low self-esteem
- Alcohol/drug and / or substance misuse
- Poor social skills / highly developed social skills
- An inability to negotiate difficult situations or the opposite
- Developmental delays in younger children
- Anxiety about their own identity
- Fear of being the same as their parents / determination not to be the same.

Children may be encouraged to join in the abuse and they may replicate the violent behaviour. Consequently there may be a whole new set of issues to be discussed and addressed and which will have further implications for both parents and siblings of the child.

Any of these indicators on their own or together, do not necessarily mean that there is domestic violence occurring within a family. However, workers should be aware of the issues and the impact on children. Where there are concerns about children they work with and suspect that there may be domestic violence happening, then they should consider how they are going to deal with the issue and their concerns.

## The Impact on Women

The following list is of possible effects of domestic violence on women. It is not exhaustive and often there can be any number of inter-related effects evident at any one time.

- Continual and persistent fear
- Feelings of worthlessness and inadequacy; lack of confidence
- Inability to think clear, make decisions and make choices
- An erosion of self-esteem
- Feeling undermined and blamed
- Not allowed to develop / inability to maintain meaningful relationships
- Isolation from friends, family and community
- Inability to settle and lack of sleep
- Tiredness and lack of energy / too much energy
- Physical ill-health
- Mental ill-health or the appearance of mental health symptoms
- Eating disorders; self-harm; suicide
- Feeling that there is no way out of the situation
- Alcohol and / or drug use as a coping mechanism
- Violence often escalates during pregnancy
- Children may be conceived as a result of rape

Because of the complexities, it may not be easy for a woman to make a decision to leave a relationship and a worker's responses to her may be crucial in how she responds next. It is usual for all of us to take our time in making major decisions in our life and to consider the range of possible consequences.

In circumstances of domestic violence, it is necessary for workers to take into account one of the main consequences, that of an erosion of self-worth and self-esteem in all aspects of their lives. Workers should not be surprised if the woman appears to be indecisive and unsure and she may change her mind. The woman should not feel pressured or blamed or judged if she feels unable to leave a violent partner or if she returns to one.

## The Impact of Parenting

Domestic violence is usually committed in the context of an abusive environment within the home. There are likely to be high levels of punishment, the misuse of power and authority by the perpetrator of the violence and a failure of appropriate self-control together with feelings of fear, anxiety and helplessness. It is therefore highly likely that this situation will affect how both adults parent their children. Consequences which may apply to either or both parents can include:

- Loss of self-confidence as an individual and as a parent
- Inability to bond and form a relationship with the child
- Feeling undermined as an individual and as a parent
- Feeling emotionally and physically drained, with little to give the children
- Not knowing what to say to the children or how to help them come to terms with what they are experiencing

- Emotional distance between parent and child
- Inability to support the children
- Inability to deal with children's behaviour
- Lack of financial support / poverty
- Potential to take out their frustrations on the children
- Inability to provide appropriate boundaries, structure and security to the children
- Home environment not conducive to support educational needs

It is important not to solely focus on the mother as the only parent of the child and that the role of the father needs to be clarified and understood. It is also important to understand the dynamic of the perpetrator's relationship to other members of the family and although it may not be easy to work with perpetrators of violence, workers must consider the services required to meet the need for his behavioural change.

### Confidentiality and Safety

All professionals working with families where there is actual or potential domestic violence must consider issues around confidentiality and safety. Workers also need to be aware of each agency's boundaries of confidentiality and to be clear about roles and responsibilities. Not only must the normal roles of confidentiality be observed, it is also essential to take into account the potential consequences for the women, the children and any workers who may be supporting the family. Also to exercise caution when disclosing ANY information to the person who is violent, or that person's representative (eg Solicitor, family member, friend). This applies in all circumstances of domestic violence, whether the woman is living at home, in a refuge, in a hostel or bed and breakfast accommodation.

### Procedures

Children and young people who experience domestic violence in some way, by witnessing it directly or by being aware that it is happening, are likely to be defined as children 'in need' under Section 17 of Children Act (1989).

Research evidence indicates that some of these children may also be at risk of, or have experienced significant harm themselves.

In all circumstances in which children experience domestic violence, agencies need to work together quickly and effectively and in partnership with the family to safeguard and promote the welfare of the child.

Assessment and service provision by adult and childcare agencies need to be integrated wherever possible and should always be co-ordinated by the Children and Families Team to ensure a coherent approach to supporting the family.

The need for confidentiality and sensitive handling of information regarding families who are experiencing domestic violence should be a working assumption, and consent should normally be obtained before information is requested and passed on. Circumstances in which the need for consent can be over-ridden are situations where a child is considered to be at risk of significant harm. The passing of information from Police and Social Services regarding domestic violence incidents where children are involved contributes to an on-going assessment of this risk.

Where domestic violence is occurring in a family who are black or from an ethnic minority, issues relating to cultural beliefs and language should be taken into consideration when both communicating with the family and assessing the risk to the child. If necessary specialist advice should be sought.

In situations of domestic violence the women must be given the opportunity to talk to Social Services staff on their own, separate from the perpetrator or violence. If this is not done the woman may deny the violence, or minimized the extent of the violence because of fear of the consequences.

## **Individual Agency Response to Incidents of Domestic Violence Where Children are Present**

### **Police**

A Domestic Incident Form should always be completed when a Police Officer attends an incident.

A number of issues should be considered and entered on the form under the 'Officer's Comments' section:

- Did a child directly experience violence during the incident - physically, emotionally and sexually
- Has the family agreed for the Domestic Incident form to be sent to Social Services / other agencies
- Is the family requesting assistance.

If a child is believed to have suffered, or is at risk of significant harm, child protection procedures must be initiated immediately.

In all circumstances the Domestic Incident form should be faxed to the Domestic Violence Unit by the end of the shift. The Domestic Violence Unit will fax a copy to the appropriate Children's Social Care team and liaise with the Police Child Protection Team.

### **Children's Social Care Response to Incidents of Domestic Violence Where Children are Present**

Upon receipt of a Domestic Incident form, or information received from another agency regarding domestic violence, the children and families team will consider the most appropriate response, using the following guidelines.

If there is reason to believe that a child is suffering or is at risk of suffering significant harm; child protection procedures will be initiated if this has not already occurred. If the incident is considered 'serious', an Initial Assessment using the Department of Health 'Framework for Assessment' should be undertaken. 'Serious' within this framework should be defined in terms of the impact on the child, as identified by the Police or other agency.

If there is a serious incident or there have been three reported incidents which have not been considered serious, but where a child has been present, an Initial Assessment should be undertaken.

When making contact with a family following receipt of a Domestic Incident form, careful consideration should be given to the safety of the victim of domestic violence. Consultation with the Domestic Violence Unit is important in this situation.

Families who have experienced domestic violence should be supported by the provision of Family Support Services and should be diverted from the formal Child Protection system whenever it is possible and safe to do so.

Should the woman choose to move out of the violent situation, support should be offered to enable her and the children to recover and achieve independence. This will involve a number of agencies in order for all necessary information and advice to be obtained and options explored.

If a woman chooses to stay in a violent relationship, there needs to be a clear assessment of the risks to her and the children and how those risks can be minimised and managed by positive intervention. Information should be given about specialist domestic violence services so the woman knows where support is available should she need it.

### **Other Agencies Response to Incidents of Domestic Violence where Children are Present**

Whenever an episode of domestic violence comes to the attention of an agency that has contact with a family, consideration should be given to the likely impact on the child and to the possible risk of significant harm.

If there is reason to believe that a child has suffered or is likely to suffer significant harm, the agency must contact the Advice and Assessment Service who will make enquiries under Section 47 of the Children Act 1989.

Referrals should be made in partnership with the non violent partner, however the child's welfare and safety is the paramount concern.

In all other circumstances a referral should be made to Children's Social Care who will ask other agencies to contribute to an initial assessment if one is to be undertaken.

### **Child Protection Conferences**

When a Child protection Case Conference is convened, there are a number of issues to be addressed before, during and after the meeting, and the following is guidance for addressing situations where there is knowledge of domestic violence.

The Social Worker convening the Case Conference (or their manager) will have clear views, based on evidence, about risks to both family members and workers.

Based upon the above, the chairperson and Social Worker will make decisions regarding parental participation; whether parties should be kept separate, and how issues of confidentiality and safety should be given to the venue of the meeting being kept confidential because of risks of violence before, during and after the meeting.

Where a violent person is to be excluded from the meeting, this should follow the current guidelines.

Workers from Refuges and domestic violence services should be invited to attend. However, potential risks to them should be discussed and if appropriate

a report should be submitted instead.

The Child Protection Outline Plan drawn up at the conference should take into account the risk of further violence to any party and seek to reduce and manage these in addition to minimising and managing risks of child abuse. Mothers are unlikely to be able to protect their child / children if they are at risk of violence themselves.

Case Conference minutes should be closely checked to ensure that if necessary the non violent partner and children's details are not disclosed as to do so could result in further violence.

### **Uxoricide - When Parent Kills Parent (further reading Harris Henriks "When Father kills Mother")**

#### **General**

Uxoricide is frequently the culmination of a history of domestic violence. The impact on the child is often severe and long-lasting. When one parent kills the other the following issues need to be considered:

- The investigating Police Officer should inform Children's Social Care of the incident and the names and ages of the children involved.
- If the child is a potential witness, the procedures laid down by the Memorandum of Good Practice and Achieving Best Evidence will be followed.

#### **Placement**

Urgent expert advice must be sought if a family placement is being considered. A child should not be placed with the family of the alleged perpetrator other than in the most unusual and carefully evaluated circumstances.

A placement must not be allowed to become long term by default.

#### **Statutory Intervention**

The Local Authority should consider the need for early statutory intervention and the necessity of gaining independent representation for the child.

#### **Therapeutic Help**

Urgent consultation with the Child and Family Mental Health service should take place to ensure that the child's immediate and long-term needs are met.

## **Assessment of Need**

A comprehensive assessment of the child should be compiled to enable appropriate planning to take place. Family members, Health workers and the Education department will be able to contribute to the child's assessment. It is essential to understand what the child has experienced in order to plan therapeutic help and placement plans for the future.

## **Contact**

The child will need to have appropriate contact with family members. If the child is a potential witness in the case, then any decision about contact with the alleged perpetrator will need to be taken in consultation with the Police and the Crown Prosecution Service.

## **Criminal Injuries Compensation**

An application to the Criminal Injuries Compensation Board should be made on behalf of the child. Please refer to the guidance.

## Children deprived of necessary Medical Treatment by virtue of the Beliefs or Personal Agenda of the Parents

### General

All medical practitioners have a duty of care towards the child and must ensure the interests of the child take precedence.

- 1.1 The clinical care of all children admitted to any NHS Trust hospital facilities is supervised by the admitting Consultant, who is responsible for the clinical decisions involved in the management of the care of the child.
- 1.2 In the case of a medical emergency, immediately necessary or life preserving treatment can be given without the need to obtain a court order, even if valid consent is not available. In such circumstances it is good practice for the medical practitioner to have “a second opinion” of a colleague.
- 1.3 In some circumstances, children may be in danger of being deprived of necessary medical treatment by virtue of the beliefs or personal agenda of the parents.
- 1.4 A child who is “Fraser competent” (that is under the age of 16 but yet having sufficient maturity and understanding of the nature and implications of the proposed treatment) can give or refuse valid consent for it. However, a refusal can be over ridden by a Court Order.
- 1.5 Where it is deemed clinically necessary, for specific medical interventions that are declined by those with parental responsibility, it may be necessary to initiate legal proceedings, in order to carry out treatment and protect the child.
- 1.6 It is to be anticipated that this would only be undertaken after a period of discussion and consultation with the parents and the patient, if the patient were of sufficient age and understanding. The parents would be fully informed of the need for a specific treatment to be administered to their child and that clinically there is every reason to suppose that it would be to the significant detriment of the child if these treatments were withheld. If it is possible the medical practitioner would come to an accord with the person/s who have parental responsibility and again the medical practitioner should seek a “second opinion”.
- 1.7. Under these circumstances, it is recommended that the Consultant concerned applies for a Specific Issue Order under Section 8, The Children Act to the High Court. This is a straightforward procedure that would allow a direction to be made by the court as to the giving any necessary treatment. All aspects of the child’s care, other than their medical treatment, would remain under these circumstances the responsibility of their parents/those with parental responsibility. For details of procedures to follow reference should be made to individual NHS Trust Child Protection Procedures.

- 1.8 Consideration will need to be given to the parents and child's rights to respect for their private and family life and to their right to freedom of thought, conscience and religion. Any interference with those rights will have to be designed to achieve a legitimate objective and to be proportionate to achieve the end. Previous decisions of the High Court have usually led to treatment being secured in the face of parental opposition.
- 1.9 Under these circumstances, it is required that the Consultant in charge of the case liaises with the following personnel:
- The Consultant Paediatrician on call, when the admitting Consultant is from an alternative Directorate. It would be deemed good practice for a Consultant Paediatrician to seek a second opinion from a suitably qualified colleague.
  - The Advice and Assessment Service or Out of Hours Team (Children's Services) who may instigate an Initial Assessment and decide whether there is a requirement for a Strategy Meeting.
  - The NHS Trust's Legal Advisers
  - The duty Hospital Manager
- 1.10 The supervising Consultant, in conjunction with the Social Care, must ensure the parents are fully supported throughout the process.
- 1.11 The NHS Trusts Medical director, Named Doctor for Child protection and Named Nurse for Child Protection must be fully informed when the above Procedure is used.

## Fabricated or Induction of Illness by Carers (FII)

### Introduction

FII was first described in 1977 and at the time was referred to as Munchausen Syndrome by Proxy. There has been controversy over the most appropriate terminology but the term 'Fabricated or Induction of Illness by a Carer' has been accepted to keep the focus on the welfare of the child.

There are three main ways a carer may fabricate or induce illness in a child:

- Fabrication (invention) of signs and symptoms of physical or mental illness. This may include the past medical history.
- Fabrication of signs and symptoms and falsification of hospital charts or records or specimens of bodily fluid.
- Inducing (causing) illness by various means, for example:

- administering substances
- smothering
- withholding food or medicine

N.B. The child may present with an acute life threatening event.

### Recognition of FII

The following may be indicators of a possible diagnosis of FII:

- Reported symptoms and signs are unusual or bizarre and are not explained by any medical condition.
- Physical examination and results of medical investigations do not explain reported symptoms and signs.
- Over time the child is repeatedly presented with a range of symptoms and signs often resulting in multiple medical procedures.
- Acute signs and symptoms cease when the child is separated from the carer who is the perpetrator.
- New symptoms are reported on resolution of previous ones.
- There is unexplained poor response to prescribed treatment.
- Unusual / unexplained illness or death of previous children.

FII should be distinguished from:

- parent / carer who is over-anxious about trivial symptoms, and frequently seeks medical advice
- exaggeration of symptoms to convey genuine concern about a child's health or to receive financial benefits.

It is important to recognise that a child may have a genuine organic illness but be presented with fabricated symptoms. This makes a diagnosis of fabricated illness difficult as the presenting symptoms may be similar to that of the organic illness.

## Understanding FII

The underlying condition is a psychiatric disorder in the parents / carer in which the ability to distinguish the child's needs from their own, is compromised. It is a long-standing and severe disorder. The perpetrators may have a history of being abused or subject to an attachment disorder.

There are a number of recognised characteristics which perpetrators may show. These are as follows;

- A female carer and in most cases the mother.
  - May have a considerable medical, obstetric and / or psychiatric history.
  - Unusual knowledge about illness.
  - Have previous experience with health or caring professionals.
  - May be overly involved with their children, never allowing anyone else to undertake any of the child's care
- OR
- May be more involved with staff or other families on the ward.
  - May appear unconcerned when given results of investigations which may be indicative of a serious physical illness in the child.
  - May work in a caring profession.
  - Usually no outwardly visible concerns about parenting.
  - Serious relationship problems are common.
  - Fabricator's partner is often unassertive and occasionally colluding.

## Responding to Individual Cases

All agencies and professionals should be alert to potential indicators of illness being fabricated or induced in a child.

In order to safeguard the child's welfare it is important that the medical professionals, Social Care and the Police work closely together in making and taking forward decisions about future actions, recognising each others' roles and responsibilities, after actions.

Protection of children from abuse demands;

- Good cooperation between all professionals involved
- Keeping an open mind to all concerns
- Always focusing on the best interest of the child

## Medical Responsibilities

In most cases concerns about the possibility of fabricated or induced illness are first recognised in the hospital setting because medical findings or their absence provides evidence of this form of abuse. The majority of the children will be under the care of a consultant paediatrician or / and a child mental health consultant.

Whenever it is suspected that some or all of a child's symptoms are being fabricated or induced by a carer, a named consultant should;

- Take lead responsibility for the child's healthcare.
- Consult the named or designated doctor.
- Ensure a high standard of record keeping and ensure records are kept secure.
- Consider whether immediate action needs to be taken to secure the safety of the child (and siblings).
- Produce a medical chronology from the medical notes including those from primary care.

Other health care professionals may also become concerned about the possibility of FII and those concerned should be discussed with the Named or Designated Professional in the Trust in which they work.

Adult mental health professionals, through their involvement with a parent or carer, may become concerned about the welfare of a child, particularly if a carer is known to induce or fabricate illness in themselves. These cases can pose conflicts of loyalty but adult mental health professionals should have a duty to consider the welfare of a child and any concerns should be discussed with a Named or Designated Doctor in their NHS Trust.

## Referral to Social Care

- When a diagnosis of FII is being considered, and as a result the child health development is, or is likely to be impaired, a referral should be made to Social Care.
- Professionals should be cautious about the potential dangers of alerting carers to the concerns as this places the child at increased risk of harm. All decisions about what information should be shared with parents, when and by whom should be taken by a multi-agency consensus.
- A telephone referral should be followed up in writing within 48 hours.
- Following referral, Social Care should decide within 1-working day what response is necessary. Lead responsibility for the action to safeguard children lies with Children's Social Care.

## The Police

The Police should be involved as early as possible as with any suspected case of FII may involve the commission of a crime and the Police are responsible for gathering evidence in criminal cases.

## Immediate Protection

If at any point there is medical or other evidence to indicate that a child may be at risk of death or serious harm, an agency with statutory CP powers should act quickly to secure the immediate safety of the child.

The nature of the abuse will be the key determining factor i.e. if it is known that a child is being intentionally suffocated or poisoned then immediate action needs to be taken. If there is verbal fabrication only, it is unlikely that it will be necessary to act as quickly to secure the immediate safety of the child.

Decisions about possible immediate action need to be kept under constant review, as for example the child may become more at risk if the carer becomes aware of the concerns.

When considering whether emergency action is necessary an agency should also consider whether action is required to safeguard other children in the household.

## Strategy Meeting

If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm as a result of possible induced / fabricated illness, children's social care services should convene and chair a strategy meeting. In this complex type of abuse the most effective way of professionals discussing the child's welfare and planning future action is likely to be by meeting together rather than by discussions on the phone.

If a health professional has made a probable diagnosis of FII this should not be rejected without a strategy meeting having been held.

As a minimum the strategy meeting should include Children's Social Care, the Police, the medical consultant responsible for the child's health and, if the child is an in-patient, a senior ward nurse. Consideration should also be made to inviting a medical professional who has expertise in the branch of medicine which deals with the symptoms and illness processes caused by the suspected abuse.

Professionals involved with the child such as GP, Health Visitor and staff from education settings should be involved if appropriate.

The local authority's solicitor should routinely be invited to the Strategy Meeting.

Staff should be sufficiently senior to be able to contribute to the discussion of often complex information, and to make decisions on behalf of their agency.

At a strategy meeting it is vital that all available information is carefully presented and evaluated and, where possible, is accurate having been verified at source.

Where it is decided that there are grounds to initiate an enquiry under S47 of the Children's Act, decisions should be made about:

- Whether there is a need for immediate action to protect the children and other children in the household
- How the enquiry will be carried out and what further information is required about the child and family and how it should be obtained and recorded
- 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
- Whether the child needs constant professionals' observation and if so, whether the carer(s) should be present
- Who will carry out what actions, by when, and for what purpose, in particular the planning of further paediatric assessment
- Any particular factors, such as the child and family's race, ethnicity and language which should be taken into account
- The needs of siblings and other children with whom the alleged abuser has contact
- The nature and timing of police investigations, including the analysis of samples. This will be particularly pertinent if covert video surveillance is being considered. The use of covert video surveillance (CVS), is governed by the Regulation of Investigatory Powers Act 2000. CVS should be used if there is no alternative way of obtaining information which will explain the child's signs and symptoms, and the multi-agency strategy discussion meeting considers that its use is justified based on the medical information available. The surveillance should only be undertaken by the police. Good Practice advice is available for police officers from the National Crime and Operations Faculty. The Chief Executive of the NHS Trust should be kept informed of any decisions to apply to use covert video surveillance in his/her Trust.
- The needs of the parents or carers.

There may need to be more than one Strategy Discussion / Meeting in order to enable the best decision to be made about safeguarding the child's welfare. If more than one strategy discussion is held as part of a series of discussions, the Initial Child Protection Conference should be held within 15 working days of the last Strategy Discussion / Meeting.

### **Criminal investigation**

The police have a key role in assisting medical and children's Social Care Services staff understand the reasons for the child's signs and symptoms. While Police investigations may produce conclusive evidence of maltreatment, they may also conclude that the carer is not responsible for causing the child's condition or there is no evidence of a crime having been committed, allowing medical staff to continue looking for a medical problem.

Where it is suspected that a criminal offence may have been committed, it is important that the suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984. This would normally rule out, for example, the suspect being confronted with the evidence by a paediatrician or any other personnel from the statutory agencies except for the police, which is the lead investigative agency.

## The outcome of sect 47 enquiries

Concerns not substantiated. Medical tests may identify a medical condition which explains the child's signs and symptoms, and therefore no child protection action may be necessary. There could be many explanations for these symptoms, including that they are being fabricated, and it may be that the child's health will require continued monitoring to see how it progresses. It may alternatively be concluded that multiple presentations of the child are due to over-anxiety by the carer.

Concerns substantiated but the child is not judged to be at continuing risk of significant harm. There may be substantiated concerns that a child has suffered significant harm, but it is agreed between the agencies that a plan for ensuring the child's future safety and welfare can be developed and implemented without the need for a Child Protection Conference or Plan. Integrated Children's Services Social Care, in consultation with other agencies, should take carefully any decision not to proceed to a Child Protection Conference where it is known that a child has suffered significant harm as a result of fabricated or induced illness.

Concerns substantiated and child judged to be at continuing risk of significant harm. Integrated Children's services Social Care should convene a Child Protection Conference where the agencies most involved judge that the child may continue to suffer, or be at risk of suffering significant harm. This may include situations where the child's life has not been placed in immediate danger, but continuation of the fabrication or induction of illness would have major consequences for the child's long term health or development.

## Outcomes

Following identification of fabricated or induced illness in a child, by a carer, the way in which the case is managed will have a major impact on the developmental outcomes for the child. The extent to which the parents have acknowledged some responsibility for fabricated or inducing illness in their child, will also affect outcome for the child.

## References:

Working Together to Safeguard Children; 2006.  
'Fabricated or induced Illness by Carers'; RCPCH 2002.

## **Criminal Injuries Compensation**

### **General Information**

When a child has suffered an injury as a direct result of a crime of violence, they may receive an award under the scheme.

“Crime of violence” includes physical assault and sexual abuse.

To qualify for compensation, a child must have suffered a physical and / or mental injury that is serious enough to be included in the tariff bands in the scheme. The lowest level of award is £1000.

The application should be sent within 2 years of the date of incident. Applications may be accepted outside this limit if “it is reasonable and in the interests of justice to do so.” In cases involving child abuse, late applications will generally be accepted if:

- They are made on behalf of the child, or made by the children themselves within a reasonable time limit of reaching the age of 18; and
- It seems likely there is enough supporting evidence to make an award.

The incident must have been reported to, and investigated by the police. An offender does not have to be charged or convicted before an award can be made.

In making an application, the best interests of the child must be of paramount importance at all times. If the child is of sufficient age and understanding they should be consulted about making a claim.

Parents should be made aware of the scheme, if appropriate, and will normally make the application on behalf of their own children.

### **Claims for injuries before 1 October 1979**

The scheme cannot pay compensation if a person was injured before 1 October 1979, and if the child and the person who injured them were living together as members of the same family.

### **Special Conditions in Family Cases**

Any person who causes an injury must not benefit from an award paid to the victim. Therefore it is unlikely an award will be made if there is a continuing close link between the victim and offender which makes it likely the offender may benefit from the award.

If the application is made by or on behalf of a child, the Criminal Injuries Compensation Authority would need to be satisfied that it would not be against the child’s best interest to make an award.

## Children Who Remain With Their Parent(s)

The Initial Child Protection Conference should consider advising parent(s) of their right to make a claim on behalf of their child.

The task of advising the parents about the scheme should be allocated at the conference. It would normally be the Social Worker or Keyworker.

The parents, who may obtain legal advice, are responsible for completing the claim form. Assistance in completing the form may be given by the Social Worker.

Care must be taken by the professionals that advice and help given cannot be construed as inappropriately prejudicing any investigation.

Clear guidelines from the CICA indicate that any claim / award will be invalidated should there be any risk that the sums awarded might benefit or be accessed by the perpetrators of the abuse.

## Guidance for Applications where the Child is in Care

At the first Review, consideration will be given to making an application for compensation.

The injury must be serious enough to qualify for at least the minimum award under the tariff and there must have been a Police investigation. If the injury meets these criteria, there should be a presumption that an application will be made. The views of the child should be considered. Legal advice should be sought as to the appropriateness of making a claim if there is any doubt as to the seriousness of the injury and its effect.

It is important to record clearly the reasons for either making an application or not. The decision should be referred to the Head of Service for endorsement and this should also be clearly recorded.

Except in exceptional circumstances, claims must be made within two years of the incident giving rise to the injury or, in cases of multiple incidents of child abuse, one year of the most recent incident.

The form should be filled in with the child if they are of sufficient age and understanding. Social Workers should not sign the application. The Assistant Director of Social Care or his / her nominated deputy must sign the application. If the child is aged 14 or over their signature will be needed on the application form.

Any proposal to rehabilitate/reconcile the child with the assailant needs to be brought to the attention of the CICA, as that it is likely to invalidate any claim.

The completed application forms and reports should be forwarded to the Local Authority Legal Services who will check the details.

Should the Social Worker receive any communication directly from the CICA, this should be forwarded to the Head of Service.

The Assistant Director, Children's Social Care should be consulted with regard to making a decision.

If the child is aged 14 or over, they will be consulted about the award and their signature will be needed on the acceptance form.

In the event of an appeal, it may be necessary for the Head of Service, Local Authority Legal Services, Social Worker and the child to attend an appeal hearing.

Any award is invested for the child by the finance department of the appropriate Authority.

If a child is adopted, prior to an award being made the Social Worker will discuss with the adoptive parents whether they wish to take over the application and take responsibility for investment of any award or whether they wish to leave the application with the Local Authority to pursue.

Any proposed award from the CICA should be discussed with the adoptive parents. If either an award has been made prior to the adoption or the adoptive parents wish the Local Authority to pursue an application on their behalf, the adoptive parents will be invited to sit as trustees on the establishment of a trust.

Upon an award being accepted and on receipt of the sum Legal Services will be notified. Legal Services will draft and ensure the execution of a trust document.

If the child remains in care, the money is held in trust until the child's 25th birthday. Only in exceptional circumstances would money be used prior to that date. Written requests for interim payments, detailing the amount required and the reasons and details of all financial alternatives considered, should be forwarded to the Child Protection Co-ordinator and Local Authority Legal Services who will forward the request to the trustees with appropriate background information.

Legal Services will notify the Social Worker when the money is due to be released. The Social Worker will arrange with the Legal Department to attend with the child on or after their 25th birthday so that the invested sums can be handed personally to the child. Details for claiming any income tax refund on the accrued interest, if appropriate, will also be given by the finance department.

Prior to the young person's 25th birthday, the Social Worker should ensure that the child is counselled and advised regarding the use of the money and take care to determine that the child is not immediately vulnerable to third party exploitation. Advice should be sought by the Social Worker from the Legal Department and Finance Department.

Criminal Injuries Compensation Authority  
Tay House,  
300, Bath Street,  
Glasgow  
G2 4LN

Further guidance and forms can be accessed from:

[www.cica.gov.uk](http://www.cica.gov.uk) or freephone 0800 358 3601

## Children visiting Prisons

### General

- 1.1 To minimise the risk of Prisoners attempting to pursue their paedophile activities within Prison via letters, visits, phone calls to children, and vulnerable women with children the Prison Authority has issued instruction to Prisons on Prisoner communication. (Child Protection Measures PSI 41 / 1998).
- 1.2 A Child is any child / young person under 18 years for the purpose of this document.
- 1.3 All children accompanying visitors must be named in the visiting order. Children visiting a Prisoner, on their own, will not normally be permitted.
- 1.4 When Prison staff have concerns about a named child seeing a Prisoner, they will request an assessment by Children's Services. Convicted Prisoners will be allowed to see their 'own children' only, unless it is decided that it would be a risk to these children. Other children will be permitted to visit at the discretion of the Governor of the Prison. 'Own Child,' means the Prisoners' legitimate and natural child, stepchild, and other child for whom the Prisoner has legal responsibility.
- 1.5 The Prison Service recognises the value of sharing information with other agencies including the Social Services, Police and Probation. Such enquiries will be initiated with the Police Prison Liaison Officer who will make enquiries with the Police Child Protection Team. The Prison Service may also contact directly the Social Service and Probation where they know there is relevant information.
- 1.6 Any enquiry relating to a convicted prisoner and their contact with a known child should be passed to a Police Child Protection Team so that contact can be made through the Police Prison Liaison Officer with the appropriate Prison.
- 1.7 Further advice can be found under the section on the 'Roles and Responsibilities of Prisons'.

## **Child with a Child Protection Plan** *(replaces Child Protection Register)*

### **General**

- 1.1 Every Social Services Department must maintain a central register that lists the names of children resident in the area who are considered to be at continuing risk of significant harm and for whom there is a Child Protection Plan.
- 1.2 Children who have been placed by another Local Authority or agency, are subject to a Child Protection Plan.
- 1.3 The principal purpose of the keeping a list of children with a Child Protection Plan is to make agencies and professionals aware of those children who have been judged to be at continuing risk of significant harm and in need of active safeguarding.
- 1.4 The identification of children with a Child Protection Plan never be a substitute for professional judgement and practice, but maintaining a record of children with a Child Protection Plans are central to facilitating communication between the many disciplines involved in child protection.

### **Aims of the List of Children with Child Protection Plans**

- 2.1 The aims of the List of Children with Child Protection Plans are:
  - To provide a record of children in the Local Authority area who are currently subject of inter-agency Child Protection Plans and to ensure that the plans are formally reviewed initially after 3 months and then at least every 6 months.
  - To provide a central point of enquiry for professional staff who are concerned about a child's welfare and want to confirm whether the child is subject of a Child Protection Plan.
  - To give relevant details about the child and their Keyworker.
  - To provide statistical information about current trends in the area.
- 2.2 The Designated Manager is responsible for maintaining a record of children with Child Protection Plans, held by the following:

Plymouth Unitary Authority  
Designated Manager  
Ginkgo House  
156 Mannamead Road, Plymouth (01752) 306340

## Categories of Child Protection Plans

3.1 The initial Child Protection Conference will decide whether registration is required to ensure the continuing safety of the child. Following a decision that registration should take place the chair of the conference should determine under which category of abuse the child's name should be registered. The category chosen will reflect the primary presenting concerns.

3.2

### Physical Abuse

- Actual or likely physical injury to a child, or failure to prevent physical injury. This category may also be used when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child.

### Sexual Abuse

- Forcing or enticing a child to take part in sexual activity whether or not the child is aware of what is happening. The activities may involve physical contact, penetrative or non-penetrative acts. They may involve non-contact activities such as children looking at pornographic material or watching sexual activity or encouraging the child to act in a sexually inappropriate way.

### Neglect

- The persistent failure to meet a child's basic physical or psychological needs, likely to result in serious impairment of the child's health or development. It will include the failure by a parent or carer to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or failure to ensure access to appropriate medical care or treatment.

### Emotional Abuse

- The persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on a child's emotional development. It may include conveying to a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may involve making a child feel afraid or in danger or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment.

## Enquiries to the List of Children with Child Protection Plans

4.1 The List acts as a central point of enquiry for professional staff who have concerns about a child and want to know if there are current or previous concerns or if the child is subject of a Child Protection Plan.

- 4.2 There are two types of enquiries or checks to the List:
- A general check undertaken by any agency to ascertain whether a child's name is or has been on the List and whether there is a current Child Protection Plan in place.
  - An enquiry of concern to the List, because of child protection concerns regarding a child who has suffered or is at risk of suffering significant harm.
- 4.3 Details will only be given to those agencies who are part of the Plymouth Safeguarding Children Board, or a representative of another Local Safeguarding Children Board and details will be provided on a call back basis, unless it is clear that the situation is an emergency.
- 4.4 Any Social Worker who is conducting a Section 47 Children Act enquiry on an open or new case will always contact the Designated Manager or Administrator as listed in 2.2 above and request a full check of whether the child has a Child Protection Plan. Any other agency jointly conducting enquiries in relation to Section 47 will be expected to similarly make enquiry.
- 4.5 Enquiries can be made to the List during office hours. Out of hours enquiries should be made through the Social Services' Emergency Duty Service. The contact telephone numbers for the Emergency Duty Service / Out of Hours Teams are as follows:
- Devon Social Services 0845 6000 388
  - Torbay Social Services (01803) 292166
  - Plymouth Social Services (01752) 306340
- 4.6 A record is kept of the names of the children subject of List enquiry and the advice given.
- 4.7 If a child has a Child Protection Plan, the enquirer will be given the name of the Keyworker. If the child's name is not on the List, but more than one enquiry has been made about the child or a child in the same household, enquirers will be advised to contact a previous enquirer and discuss their concerns. In addition the Designated Manager will liaise with the local Social Services office covering the area in which the child lives.
- 4.8 An enquiry is not a substitute for appropriate discussion of concerns with Children's Social Care, but as part of background information gathering.

## Contents of the List of Children with a Child Protection Plan

5.1 Information contained on the database includes the following:

- Child's full name, address, gender and date of birth
- Full names, aliases, addresses and dates of birth of parents / carers
- and other adults in the household
- Full names and dates of birth of other children in the household
- Child's school/nursery as appropriate
- Child's General Practitioner/Health Visitor as appropriate
- Child's ethnic origin
- Whether the child has legal status or a court order is in place
- Date of the initial administration check
- Reason for the Child Protection Plan, category and date of inclusion
- Name and telephone number of the Keyworker
- Other agencies directly involved with the child/family
- Recommendations of the last conference
- Date of review
- Date the child ceased to have a Child Protection Plan or when the child removed from the area
- Where moved to another area, the address and arrangements for handover
- to another authority

5.2 Any changes in the basic information, regarding a child on the List, must be notified to the Social Services administrator to the List Custodian within one working day of the new information coming to light. The List will be updated and all agencies concerned will be notified.

## No longer subject to a Child Protection Plan

6.1 A child's will no longer subject to a Child Protection Plan when it is judged that the child is no longer at continuing risk of significant harm or in need of a continuing protection plan. Consideration of removal will be taken at each review and any agency involved with the child may request a conference is convened to consider the possibility that the child no longer meets the criteria for a Child Protection Plan.

6.2 The following are grounds for no longer being subject to a Child Protection Plan include:

- It is judged the child is no longer at continuing risk of significant harm requiring safeguarding by means of a Child Protection Plan.
- Child has remained at home and completion of the core assessment, including analysis of risk has shown that registration and a protection plan is no longer required.

- The abusing adult is no longer in the household or has contact with the child or is not likely to have future contact or there is no longer risk as a result of contact.
  - Child is subject of an Interim or Full Care order or is accommodated under Section 20 Children Act 1989.
  - Child and family have moved permanently to another Local Authority area and a conference has been convened by the receiving Local Authority within 15 working days. Removal will only take place after the conference has taken place.
  - Child has reached the age of 18 years, has died or has permanently left the UK.
- 6.3 A child who is no longer subject to a Child Protection Plan may still require some form of support but this will be subject of Section 17 Children Act 1989 provision. It is expected that this will be the norm and therefore the conference that decides the child no longer needs a Child Protection Plan will draw up a Child in Need Plan. The former Core Group will be involved in on-going support to the child and family, unless it can be demonstrated that their input is no longer required. The Child in Need Plan will be subject to a review at 3 months and 6 months. The case must remain open to Children's Social Care until at least the 6 month review.

### **Failure to see a child who has a Child Protection Plan**

- 7.1 Where a professional is prevented from seeing a child, in circumstances causing concern they should inform their Line Manager and the Keyworker or if not available the Case Supervisor or duty Social Worker immediately.
- 7.2 Professionals may be prevented from seeing a child in a variety of ways such as deliberate refusal of entry, excuses regarding the child's alleged unavailability through sleep, out playing etc or the family's real or apparent absence from the home.
- 7.3 Research has shown that where a child has died often this is preceded by professionals being prevented from seeing the child on a regular and continuous basis.
- 7.4 Where a Keyworker is notified of a difficulty in seeing a child they should notify their line manager. Any agency, which has a similar problem, should likewise inform their Team Manager.
- 7.5 A decision should be made regarding the urgency for a visit to take place by the Keyworker or duty Social Worker with possible further action if that visit results in failure to see the child.
- 7.6 Delay should not occur as a result of a line manager not being available. The responsibility remains with the Keyworker or duty Social Worker.

- 7.7 Should a visit prove unsuccessful, the Keyworker or duty Social Worker must decide whether or not to enlist the assistance of the Police. Emergency action is outlined in the section on legislation and specifically on Police and Emergency Protection Orders and provisions of entry.

### **Children with a Child Protection Plan who are missing**

- 8.1 All professionals and local agencies should bear in mind when working with children and families where there are outstanding child protection concerns that a series of missed appointments or abortive home visits may indicate that a family have suddenly and unexpectedly moved out of the area. The reason could be quite innocent but at the same time professionals must be aware of some of the factors that cause such a sudden move such as domestic violence, witness intimidation, avoidance of the professionals and agencies dealing with the case etc.
- 8.2 Particular consideration needs to be given to appropriate legal interventions where it appears that, a child for whom there are outstanding child protection concerns, may be removed from the UK by his / her family in order to evade the involvement of agencies charged with safeguarding responsibilities. An urgent Review Meeting must be convened.
- 8.3 All professionals must immediately notify their manager should it come to their attention that a child who is missing has a Child Protection Plan. In the case of:
- Children's Social Care – Social Worker
  - Police - Child Abuse Investigation Team
  - Health - Designated Nurse
  - Education - Head Teacher or nominated Child Protection lead
- 8.4 In all cases where a child with a Child Protection Plan is found to be, or considered, a missing child, apart from informing their manager, any professional or agency should ensure the Designated Manager is informed as soon as possible. The Department for Children, Schools and Families holds lists which can be accessed at:  
<http://www.everychildmatters.gov.uk/resources-and-practice>
- 8.5 The Keyworker for the child will make extensive enquiries in an attempt to locate the child. Such enquiries will include the following:
- Contact with the Local Authority Legal Services if the child is subject to a Court Order.
  - Contact with all agencies that have been involved with the child including those agencies involved in first registration, and any known relatives.
  - Making enquiries within the neighbourhood, including schools.
  - Contact with the Local Authority Housing Department as appropriate.

- Contact with the Homeless Unit of the Local Authority and any specialist workers for homeless people, to ascertain if any approach has been made for accommodation
  - Contact with the Department of Social Security to initiate trace procedures
- 8.6 The Education Section of Children's Services should be able to advise on the transfer of school age children and the Health service may be able to assist where a change of Doctor has been sought by the child/family.
- 8.7 Where there is serious concern the Police should be notified through the Child Protection Teams so that consideration can be given to further enquiries including a possible missing person registration and enquiry. The Police also have means to ensure that any incident coming to their attention relating to the child or key adults will flag their whereabouts.
- 8.8 Depending on the nature and / or severity of concern for the child, the national tracing procedures should be instigated. This should however be regarded as a last resort when all other efforts to trace the child have failed unless there are clear indications giving rise for urgent concern. Instigation will take place through the Designated Manager.
- 8.9 Where a child is still missing after enquiries have been made the Keyworker will consider with their manager whether to call a Child Protection Review meeting before the next, previously set, review date.

### **Transfer between authorities of children who are subject to a Child Protection Plan**

- 9.1 When a child, who has a Child Protection Plan, or who has recently been moved to another Local Authority, it is essential that prompt action be taken to ensure the safety of the child in their new location.
- 9.2 The professional receiving such information should inform the Designated Manager as soon as possible so that relevant information can be passed to all agencies appropriate.
- 9.3 When the worker in each agency responsible for the child receives information that the child has moved, the worker is responsible for the prompt transfer of all relevant reports/records about the child to the receiving authority or area office in which the child is now living.
- 9.4 Each agency will be responsible for sending their own report and or minutes of child protection conferences about the child to the receiving authority or area office.
- 9.5 The Designated Manager will notify the Designated Manager of the receiving authority, giving them a brief outline of reasons for registration and enclosing copies of the minutes of all conferences held.

- 9.6 The child's name will only be removed from the List of children with Child Protection Plans, when the move has been confirmed as permanent, normally following a Child Protection Conference in the receiving authority.
- 9.7 Responsibility for the family is transferred to the receiving authority, at the Transfer in Child Protection conference.
- 9.8 When a child is safely placed, Plymouth (eg with foster carers or relatives) and the responsibility for the case remains with Children's Social Care of another Authority, the Child Protection Conference does not need to be convened. This matter should be discussed with the Child Protection Officer in Social Services of the relevant Authority.
- 9.9 When a child moves into Plymouth, Torbay or Devon from either one of these authorities or from another authority the following applies:
- Inform the Designated Manager
  - Inform the local Children's Social Care office
  - Contact the professional counterpart in the area of departure and ascertain whether or not the child has immediately identifiable needs within remit of an agency
  - Attend a Child Protection Conference if it has been confirmed that the move is permanent. The conference should be convened within 15 days of being notified of the move, only after which event may de-registration take place in respect of the original Local Authority's Child Protection Register
  - The child's name to be placed on one of the Child Protection Registers as a temporary registration until the conference takes place
  - Keyworkers from the place of departure to be invited to the conference
- 9.10 When a child moves out of Plymouth, or to another Local Authority the following applies:
- If this is a planned move, the Keyworker will tell the family that the facts of registration will be passed to the receiving Authority
  - If it is an unplanned or sudden move, the first professional to know should inform the Designated Manager. The Designated Manager will notify other relevant agencies of the change of circumstances. It is essential that anyone having such information does not delay informing the Designated Manager and in normal circumstances it is expected that such notification will take place within one working day of the information coming to light
  - The Keyworker would be expected to attend the Initial Child Protection Conference in the receiving Authority, if invited to do so

- If the move is permanent then the receiving Authority should convene a Child Protection Conference within 15 working days of being notified of the move, only after which event may the decision that the child no longer needs a Child Protection Plan take place in the Authority, from which the child has departed.

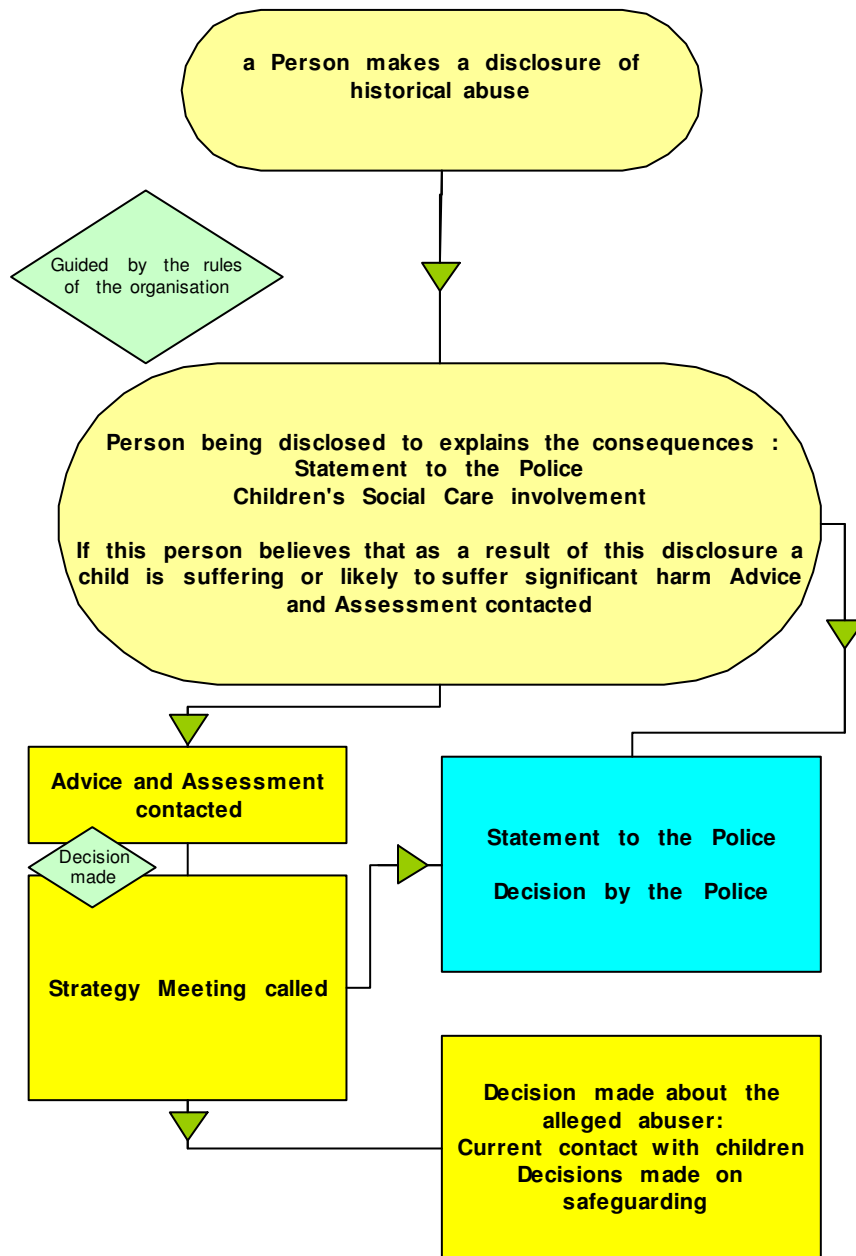
## Historical Abuse

1. There are situations when an individual discloses they have been abused in the past. It might be the first time they have talked about their abuse and often the detail takes time to be revealed.
2. When a person makes a disclosure that they have been abused in the past, it is important that they understand the consequences of informing other members of their family, making a statement to the Police and referral to Social Care.
3. Throughout the process the professional will be guided by the rules of their organisation, agency or profession, including guidance on confidentiality. The law permits the disclosure of information necessary to safeguard a child, if it is in the public interest.
4. If, therefore, a professional believes that as a result of the disclosure a child is suffering, or likely to suffer, significant harm then they should share their concerns with a statutory agency.
5. The professional should contact Children's Social Care for the area in which the person / child is living.
6. In all cases of historical abuse a formal strategy meeting must be held, chaired by a Child Protection Officer from the Charing and Reviewing Service.
7. The strategy meeting should identify the alleged abuser's current contact with children and make decisions in order to safeguard their welfare.

# PLYMOUTH SAFEGUARDING CHILDREN BOARD

## HISTORICAL ABUSE

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## Organised or Multiple Abuse

### Introduction

- 1.1 Organised or multiple abuse may be defined as abuse involving one or more abusers and a number of related or non-related abused children and young people.
- 1.2 The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework, or a position of authority, to recruit children for abuse.
- 1.3 Each investigation of organised or multiple abuse will be different, according to the characteristics of each situation and the scale and complexity of the situation. It could involve one individual abusing a number of children in their district, or a network of abusers working in the community or in establishments, such as Residential Establishments.
- 1.4 If children are to be protected, it is essential that there is a well co-ordinated response, since independent action will not secure the protection of children and may well expose them to greater risk.
- 1.5 Whatever the level and degree of abuse therefore, it is important that a Strategy Meeting is convened at the earliest opportunity, chaired by a Child Protection Officer from the Charing and Reviewing Service, which will need to ensure that there is:
  - Thorough planning with the appropriate resources to manage the investigation.
  - Good inter-agency working.
  - Attention to the welfare needs of the children involved, including support and therapeutic help.
  - Emphasis on the need to maintain confidentiality.

### Initial Action

- 2.1 An allegation or suspicion of organised or multiple abuse may be identified initially by either the Police or Children's Social Care, or through other agencies that must refer the matter to the Children's Social Care office (Advice and Assessment).
- 2.2 The Managers from the key agencies should be consulted about the allegation and if it is agreed a Strategy Meeting should be convened as soon as possible.
- 2.3 If at an early stage it is identified that there may need to be a major investigation the Assistant Director and Safeguarding Manager must be informed.

- 2.4 The Independent Chair, Child Protection for the area in which the child or children are residing should Chair the meeting. The meeting must be minuted.
- 2.6 Unless there is a need for immediate action to protect the referred child or other children then the child protection enquiries and the Police investigation should await the outcome of the Strategy Meeting. Parents must not be told at this stage about the meeting since this could prevent adequate protection for the children.

## Strategy Meeting

- 3.1 If the allegations relate to children in the community, the membership of the meeting and the agenda should follow the procedures outlined in the Strategy Meeting for Section 47 enquiries.
- 3.2 If the allegations of abuse are made against a professional, then the guidelines about abuse by professionals should be followed.
- 3.3 If it is apparent that an extensive or major investigation will be required, then in addition to following the agreed procedures for Strategy Meetings, the points below should be considered:
- Timing, parameters and conduct of the investigation.
  - Lines of accountability and communication.
  - Deployment of staff and resources.
  - Safe and secure storage of records.
  - The Communications strategy, encompassing Local Authority members, staff, children, families, the media and if appropriate OFSTED, will be organised under the Plymouth Safeguarding Children Board Communications Strategy.
  - Support and therapeutic help for the children and their families .
  - Adequate administrative support.
- 3.4 A detailed procedure in relation to major or extensive investigations is available with Children's Social Care and the Police.

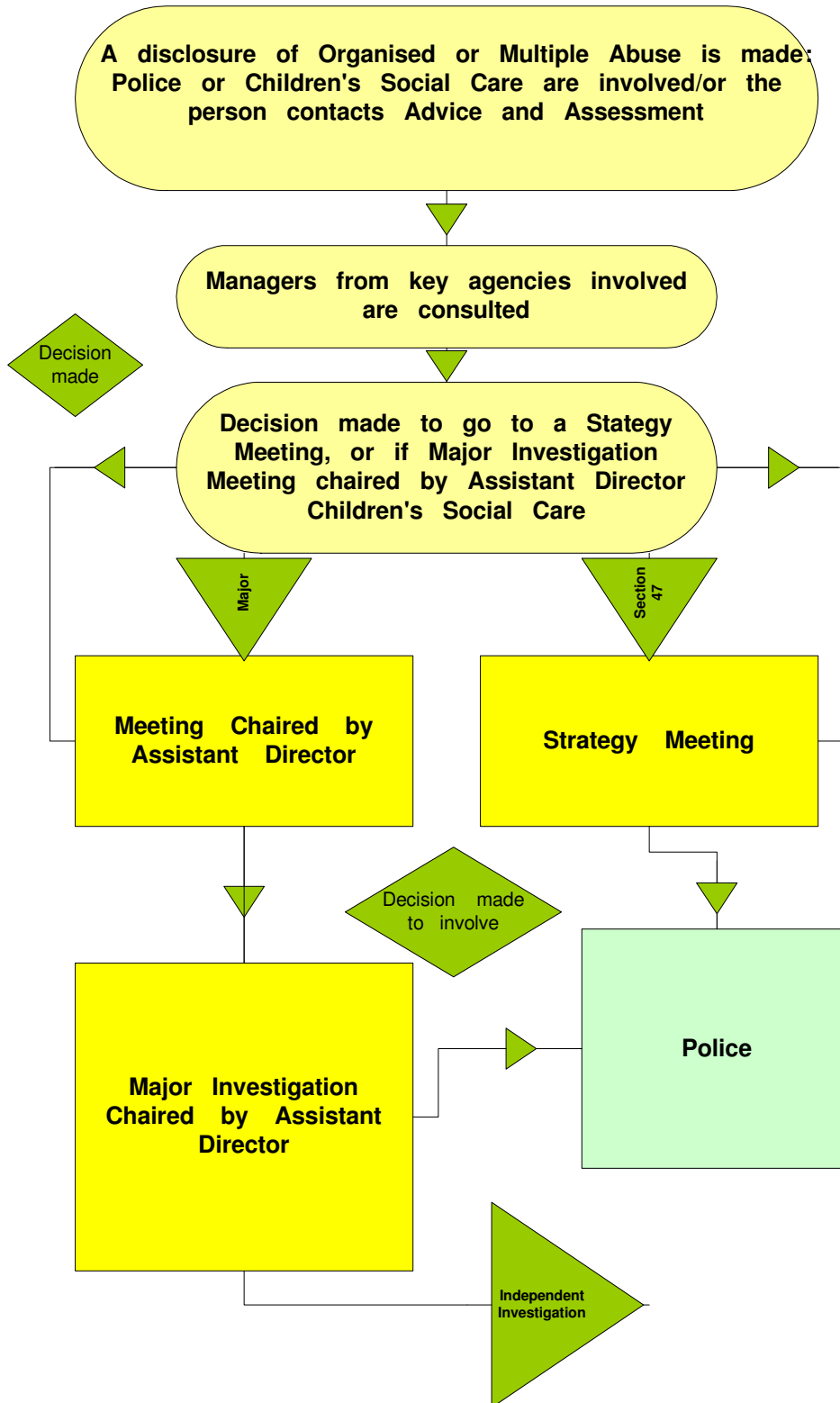
## Action Following Strategy Meeting

- 4.1 Children should be removed from their families only, if necessary to safeguard their welfare. In some cases, particularly those involving multiple abuse situations it may be important to prevent suspects communicating with each other, or destroying evidence. This might necessitate action at a time of the day when the whole family is together.
- 4.2 If a large number of children are or may be involved, advanced planning is important for their care and treatment.
- 4.3 The Strategy Meeting should be reconvened at regular intervals to ensure the plan agreed at the first meeting is reviewed and updated.

- 4.4 It is crucial that all agencies keep careful notes of all activity, carefully recording inter-agency liaison.
- 4.5 Children involved and their families should be kept as fully informed as is practicable throughout the course of the investigation.
- 4.6 Separate files should be opened on all children interviewed.

# PLYMOUTH SAFEGUARDING CHILDREN BOARD ORGANISED OR MULTIPLE ABUSE ABUSE

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## Post Protection Work

### General

- 1.1 Once alleged abuse has been investigated and confirmed, consideration will be given to whether protection from future abuse needs to be achieved formally through the child protection register or informally.
- 1.2 Remedial therapy with the child is only possible when the child feels safe from further abuse but where there is a criminal investigation any therapy must comply with the section on 'Therapy pending Prosecution'
- 1.3 The first priority is to ensure an adequate protection plan. Once this plan is in place either formally through the child protection register or informally, post protection work can take place.
- 1.4 Post protection work covers all work that is necessary to reduce the risk of abuse to a minimum acceptable level. It should include:
  - Work with the non-abusing parent to identify signs of abuse, respond appropriately and avoid dangerous situations
  - Work with the child to help the child make sense of past experiences in order to assign responsibility properly to the abuser
  - Work with the abuser to control and change their behaviour so that potential abuse scenarios can be recognised and avoided.
- 1.5 Post protection work should be undertaken within the context of the agreed protection plan. De-registration should only occur when this work has started and both professionals and family have agreed that the risk of future abuse is at an acceptable minimum level.
- 1.6 Where any post protection work is required and a criminal prosecution is the likely outcome of the investigation, the child can still be referred for post protection work but the Crown Prosecution Service must be informed of the referral prior to any work commencing so that a decision can be made as to whether it will affect any future prosecution of the abuser.

## Therapy pending Prosecution in cases of Child Abuse

The Home Office (HO), Crown Prosecution Service (CPS) and Department of Health (DoH) have produced a document called 'Provision of Therapy for Child Witnesses Prior to a Criminal Trial 2000'. The following paragraphs précis this extensive documents but for detailed advice the above document should be read.

In the past, therapy has been denied a child pending the outcome of any criminal trial for fear that the evidence will be tainted and the prosecution lost. The likelihood of a prosecution being jeopardized is thought to be greater if Therapy takes place before the video recorded interview has been completed.

This is in direct conflict with ensuring the victim is able to have immediate and Effective treatment, regardless of other interest, to assist recovery as soon as Possible. The best interests of the child are the paramount consideration in decisions about the provision of therapy before the criminal trial. In determining what is in the best interests of the child, due consideration should be given to ascertaining the wishes and feelings, in a manner which is appropriate to the child's age and understanding and account should be taken of the child's gender, race, culture, religion, language and (if appropriate) disability.

'Working Together To Safeguard Children' paragraph 5.8 sets out the interagency processes for enquiries under Section 47 of the Children Act 1989. The Child Protection Plan should describe the identified needs of the child and what therapeutic services are required.

If during this planning stage, it is known that the child is to be a witness at a criminal trial, considerations should be given to:

- The child's therapeutic needs
- The possible impact the provision of therapy might have on the criminal trial
- The consequences for the child of either proceeding with the therapy or deciding not to, having taken account of the implications for the criminal trial.

The Home Office and the Department of Health 'Memorandum of Good Practice', paragraph 3.44 states, 'It should be possible for appropriate counselling and therapy to take place once a video recorded interview is complete. It should be standard practice to inform the Police and CPS about the nature and content of the therapy in each case. The defence may justifiably wish to know about both the nature and content of the therapy that has taken place before the child gives evidence in cross examination'.

There are three broad types of pre-trial intervention that can be identified:

- Preparation for court focuses on the preparation of the child witness for the giving of evidence in a criminal trial and the young witness pack makes the distinction between preparation and therapy. This is normally carried out when required by young witness supporters. The investigation team should make referral to the Young Witness Support Services.

- Educational and preventive work: This should be carried out by teaching children how to stay safe and to improve their self-esteem and confidence.
- Individual and group therapy to treat emotional and behavioural disturbances, for example post-traumatic stress disorder.

If therapy is considered prior to trial, it is envisaged this would focus on individual rather than group therapy where the recounting of abuse takes place. This avoids a witness adopting the experiences of others taking part in the group therapy.

Two broad categories of therapeutic work undertaken prior to a criminal trial can be identified:

Counselling which will address:

- The impact on the child of the abuse
- Improving the self-esteem and confidence of the child
- Providing the child with information with regard to, for example abusive relationships, with the aim to enable the child to seek out assistance from trusted adults if the child feels unsafe at some stage in the future

Psychotherapy which will address:

- Treatment of emotional and behavioural disturbance, for example posttraumatic stress disorder
- Treatment of a child who has been highly traumatised and shows symptoms which give rise to concern for the child's mental health. Children may derive therapeutic benefit from simply talking about their experiences. Professionals concerned should be aware of the possible consequences of allowing it to happen. These may include allegations of coaching and, ultimately, the failure of the criminal case. It should also be borne in mind that the professionals concerned may themselves be called to Court as witnesses in relation to any therapy undertaken prior to the criminal trial.

## Procedures

The contents of these guidelines are aimed at therapy offered within the NHS, Children's Social Care and the voluntary or private sector.

A number of factors relating to qualifications, training and experience can guide the relevant professionals about the competence of any single individual to undertake psychotherapy or counselling with a child who is to be a witness in a criminal trial.

Providers and purchasers of therapy for children in this situation must ensure that any therapist or counsellor has appropriate training according to the level of work to be undertaken, as well as a thorough understanding of the effects of abuse. Membership of an appropriate professional body or other recognized competence would be expected in these circumstances. They must also have a good

understanding of how the rules of evidence for witnesses in criminal proceedings may require modifications of techniques.

### **Assessment for Therapy**

At a Strategy Meeting or Case Conference the need for and the feasibility of therapy should be considered. The meeting can recommend that an approach be made to therapy services for advice, consultation and for possible assessment. This could be as part of an assessment undertaken according to the 'Framework for the Assessment of Children in Need and their Families (Department of Health et al 2000)'.

The assessment will address the following areas:

#### **Developmental Factors**

- The child's development in both emotional cognitive terms as well as any relevant physical illness or developmental problems which might affect a child's performance as a witness in Court, and which could be worked within the course of therapy provided prior to the criminal trial.

#### **Specific Needs**

- An assessment of children with specific needs including physical and learning disabilities, hearing and speech impairments so as to make the child with appropriate assistance be a competent witness.

#### **Suggestibility**

- The issue of possible suggestibility in an interview situation, or during cross examination in Court should also be addressed during an assessment.

#### **Assessment Tools**

- A limited range of selected assessment tools such as drawing materials and appropriate toys (for example non anatomical dolls) can be used but the use of any materials which suggest or presume that abuse has taken place should be avoided.

#### **Psychological / Developmental Assessment**

- Where deemed clinically appropriate a separate psychological and / or developmental assessment should be completed to obtain base line data cognitive and emotional functioning.

#### **Action to be taken**

- The Crown Prosecution Service (CPS) should be informed by the Police Officer in case at the earliest opportunity when a recommendation to approach therapy services has been made.
- The Police Officer in case should ensure the CPS is made aware of any therapy either taking place or likely to take place. This does not preclude individual communication between Therapists and the CPS.
- The Police will indicate the use of therapy to CPS on the confidential information form submitted with the Police file.

A primary consideration for Crown Prosecutors when taking decisions in these circumstances is the best interests of the child. The Prosecution in these criminal cases must do what it can to:

- Identify cases in which the provision of therapy before the criminal trial might be thought to have some material impact on the evidence
- Assess the likely consequences for the criminal trial in these cases
- Ensure that these cases are dealt with as quickly as possible
- Safeguard the confidentiality of therapy sessions wherever possible whilst ensuring that the defence and the court are aware of the existence of information which might undermine the Prosecution case or assist the Defence.

The CPS should comment if it is felt the evidence will be jeopardised by therapy and these views confirmed in writing. This should lead to a discussion between the CPS, the police, the Therapist and Children's Social Care about the CPS comments. The discussion should also include the possibility of alternative ways forward, including any alternatives to therapy. It may require a reconvening of the Child Protection Conference if there is a view that therapy may jeopardise the criminal proceedings. This meeting should also consider the views of the parents / child and what is in the child's best interest.

Where a criminal case is at an advanced stage, it may be possible to consult the judge in chambers as to the potential consequences of a proposed course of action

If the case does not come within child protection procedures, the discussion between CPS, Therapist and the Police may also have to consider the views of the parents and also of the child if of sufficient age and understanding.

The Therapist should be made aware of any pending criminal proceedings before commencing the therapy and should also be aware of the implications of using techniques that may result in the child's evidence being discredited. The content of the investigative video interview and the statements involving evidence of the abuse should not be discussed with the abused. Therapists may wish to indicate to the child why they cannot do so for instance to prevent contamination of evidence and maintain credibility.

Limitations of usual confidential arrangements between clients and Therapists will be modified while a prosecution is pending. Therapists will need to make themselves aware of these limitations through consultation with the Police Officer in case and the CPS.

Careful maintenance records should be kept of any therapy. Such notes may be subject to disclosure as third party material in criminal proceedings as well as civil proceedings.

The rules of disclosure place certain responsibilities on the investigator, Prosecutor and also third parties, that is to say individuals or bodies who are not part of the prosecution. Therapists will generally be third parties for this purpose. Those responsibilities mean that all material that may be relevant to the issues disputed in the case must be preserved.

They should include in their records, in the case of therapy, details of those persons present and the content and length of the therapy sessions. It is not expected for practical reasons that verbatim written records will be kept.

Therapists may be called upon to explain to the Court the process of therapy. If fresh evidence comes to light during the course of therapy, the Therapist may be called to give this evidence on behalf of the Prosecution or the Defence.

Where significant additional allegations of abuse are revealed, possible disclosure of abuse by the victim or any material departure or inconsistency with the original allegation the therapy should be stopped at that point in the session so that this can be treated as per the guidance in this Handbook. The child should be listened to but no questions asked and the investigation team advised.

Clearly, when therapeutic work is in process, disruption of therapy should be avoided even if new investigations must be conducted. If it is decided that leading questions or interpretations must be used to help a child in psychotherapy, then the evidential implications of this should be understood and made clear. It should not be left to the family to refer further to the police. This information should be carefully recorded.

Therapists undertaking work with children and adolescent's pre-trial are strongly advised to work with supervision.

Ultimately, the decision about therapy should depend upon the best interests of the child. This remains the primary consideration. If there is a demonstrable need for the provision of therapy that may prejudice the criminal proceedings, consideration must be given to abandoning those proceedings in the interest of the child's well being. Alternatively, there may be some children for whom it will be preferable to delay therapy until after the criminal case has been heard, to avoid the benefits of the therapy being undone. This impacts upon the prosecutor's duties and makes it essential that the information regarding therapy is communicated to the prosecutor.

Professionals should avoid the use of jargon and take care to use language that will not be perceived, if repeated by a child witness, as evidence to the witness being instructed. The child should guide the language content of the therapy and counselling sessions but equally it must be recognised that children do use different forms of language in differing situations and context.

## **Distribution, Retention and Destruction of Records**

### **General**

Staff from individual agencies will maintain their own records of work in child protection. These records will be subject to the arrangements for maintaining confidentiality and allowing client access appertaining to each individual agency.

Well kept records are essential to good child protection practice and each agency should have a policy stating the purpose and format for keeping records and should include a policy in respect of destruction. The needs of the Data Protection Act 1998 have to be addressed in this respect.

Clear guidance needs to be given in the agency's policy and practice in respect of file/information transfer when a child on the Child Protection Register moves out of the Plymouth LSCB area. .See the section on 'Child Protection Register'.

### **Child Protection Conference Records**

These records primarily consist of child protection conference minutes and reports to Child Protection Conferences but may also apply to Strategy Discussion documents.

Minutes will not be sent to any person or agency that does not subscribe to the PSCB policies on confidentiality of records.

One copy will be sent to all those invited to the meeting including the Guardian ad Litem/ Court Welfare Officer if they attend. They must not be copied except with the Chair's approval.

### **Retention**

Conference minutes must be stored in secure filing cabinets and restricted to only those who need to know their contents, unless they are in use. Before filing, their contents must be checked for accuracy and any discrepancy immediately reported to the chair of the meeting.

Where records are stored electronically, there must be sufficient safeguards in place to enable access only by authorized individuals.

Where a child is on the Child Protection Register and moves out of the PSCB area the complete set of the minutes should be forwarded, by the Custodian of the Register to the respective agency in whose area the child now resides.

A Copy of the minutes may be held by the Health Authority's Designated Nurse, Named Nurses (as per Agency Protocol) and the Devon and Cornwall Constabulary, in accordance with the Agency's procedures, for the retention and destruction of client files.

Where an agency has an open policy to files, including all medical records, the minutes should be kept in the restricted access section or a separate file if there is no such restricted section.

GPs should implement a comparable system

Where an agency is unable to securely store Child Protection Minutes, once they have been checked for accuracy, their copy should be destroyed.

### Access by Clients

All agencies should have policies that comply with Data Protection and Access to Records Act in respect of access by clients of personal information. The Data Protection Act not only applies to computer stored information but now also covers written material providing it can be searched for in a specific way. (See Data Protection under the 'Legal' section).

Child Protection records are exempt from automatic access by clients but certain restricted access will now be allowed under legislation. Before information appertaining to a conference is disclosed, written permission should be sought from third parties. This also applies to Strategy Meetings convened under Child Protection Procedures

### Destruction of Records

Minutes of Child Protection Conferences where the child was not registered on the Child Protection Register must be treated as follows:

- Minutes should be destroyed once they have been read and checked for accuracy by conference participants, if there is no individual agency policy on destruction of records.
- One copy of the minutes will be held by Children's Services on the child's file and destroyed in accordance with their policy on file destruction.
- The only form that can be retained securely is that giving child and family details and non-registration document.
- One copy of the minutes will be held by the Register Custodian. Minutes of a Child Protection Conference where the child was registered on the Child Protection Register must be treated as follows:
  - All minutes will be destroyed at the time the child is de-registered unless the agency has a policy for destruction of files in which case the minutes will be destroyed along with the file.
  - Children's Social Care must retain a copy of the minutes, held electronically.
- Minutes of Child Protection Conferences where the child was subject of an unsubstantiated investigation in respect of abuse must be treated as follows:
  - The minutes will normally be held by the investigating agencies and destroyed in accordance with the agencies policy on file destruction unless the child is subject of registration on the Child Protection Register in which case the above advice will be adhered to.

- Minutes of Child Protection Conferences about abuse by a Foster Parent will be treated as follows:
  - The Register Custodian will keep investigation details, along with reports of any conference and final recommendations.
  - A complete copy will be kept by Social Services with the file on the Foster Parent and will be destroyed in accordance with the policy on Foster Parent Files.
  - A copy will be retained on the child's file.

## Race, Ethnicity and Culture

### General

- 1.1 No society or culture finds the abuse of children acceptable. It is the responsibility of all workers to evaluate childcare practice in this context, integrated with anti-discriminatory and anti-racist practice generally.
- 1.2 The following notes should be used to inform work with all ethnic and cultural minority clients.
- 1.3 Always check to ensure that parents / carers are aware of the requirement of the law. These may differ from their cultural beliefs about child-care and may also be different from the law in their country of origin. If there are difficulties over this try to ensure that an independent person or agency gives parents advice preferably.
- 1.4 Where there are communications difficulties obtain the assistance of an interpreter on all spoken and written transactions with the family. Devon and Cornwall Constabulary have a list of persons who assist the Police when interpreters are needed. The list is available on the Force database OIS system. A list is also kept in the standby Social Work resource pack. Care should be taken that the interpreter exercises impartiality in order not to influence the course of the investigation. Any interpreter used must be made aware of the guidelines under the 'Memorandum of Good Practice'.
- 1.5 If the family has a different cultural background to that of the worker, try to obtain informed advice from someone of the same background as the family or from someone with knowledge of that background.
- 1.6 In some communities and groups extended families play an important role in family life, check whether or not grandparents and / or other relatives should be included in family meetings to discuss children's needs.
- 1.7 The absence of an extended family network may provoke greater difficulties and pressure in circumstances where culturally this would be the normal family support. This should be taken into account when offering appropriate supportive backup.
- 1.8 When parents, carers or other family members are invited to meetings with professionals, they should be given the opportunity to be accompanied by a person of their own ethnic origin or group.
- 1.9 Always consider calling upon the resources of other services, for example the Health Service, where there may be professional minority ethnic groups who are able to co-work.
- 1.10 Whilst staff/colleagues from various minority ethnic groups may be able to advise workers on cultural issues, individual workers should take personal responsibility for understanding institutional racist practice and gender discrimination and work to eradicate these.

- 1.11 'Interpretations' of behaviour/attitudes, should always be put in the context of the individual's/family's views of the 'authorities' and their effect on the behaviour towards agencies. Specialist advice should be sought if necessary to aid that interpretation.
- 1.12 If a child from a minority ethnic family is to be placed in Day/Foster/Residential or Hospital care, parents / carers must be given the opportunity to explain the child's dietary requirements or other special needs.
- 1.13 Workers should build up and maintain information regarding community resources for ethnic and cultural minority groups to assist and support isolated families in the community.

## Children with Disabilities

### General

- 1.1 Children with disabilities are children first, and as such have the same rights as other children to be protected from harm and abuse. All those caring for disabled children need to be alert to the possibility of abuse, and to recognise potentially abusive situations.
- 1.2 Children who require considerable amounts of personal care, who have few communication skills or who have severe learning disabilities will require very careful assessment. They are particularly vulnerable and are the least likely to be able to articulate fears or anxiety about inappropriate behaviour towards them.
- 1.3 Children who have disabilities should, wherever possible, have their awareness raised to the potential risks to themselves, in order to help them to recognise abusive situations.
- 1.4 Statutory and voluntary agencies caring for children with disabilities must ensure that every effort is made to assist carers in recognising the needs of such children, and ensure that they have access to child protection services. Procedural guidance relating to standards for the provision of intimate care must be available. The aim of these standards is to minimise the risk of abuse during the provision of intimate care.

### Guidance for Staff Working with Children who Have Communication Difficulties

- 2.1 This includes children who have a hearing impairment, a speech or language deficit, or severe learning difficulties.
- 2.2 Where an allegation of abuse concerns a child with communication difficulties, advice should be sought from Senior Managers and Advisory Teachers. These people will offer support and help to their colleagues in these situations.
- 2.3 A formal Strategy Meeting should always precede investigations concerning children who are disabled. This will allow a careful and thorough consideration of the child's individual needs, and any particular requirements for the investigation and assessment process. (See Framework for Assessment).
- 2.4 Consideration should be given to the use of either Specialist Teachers or Social Workers to advise on, or facilitate communications with, the child, or from specialist speech and language Therapists who will be able to advise on the application of communication systems in specific cases. These staff should have sufficient qualifications and independence to meet evidential requirements stipulated by Courts.

- 2.5 Care must be given to planning any interview with the child, using the guidance contained in the section on 'Referrals and Investigation' so that the person best able to communicate with the child can be fully prepared.
- 2.6 The investigation and any subsequent interview should be conducted in accordance with the 'Memorandum of Good Practice 1991' guidelines as set out in the section on 'Referrals and Investigation' regarding any video interviews'.
- 2.7 Throughout the investigative and assessment processes every effort should be made to explain to the child what is happening, and his / her views and wishes should be actively sought and recorded. Assumptions should not be made about the ability or inability of children to understand the procedures.
- 2.8 When undertaking any assessment, or considering a Child Protection Plan, reference should be made the requirements of The Children Act 1989 – 'Guidance and Regulations Volume 6 - Children with Disabilities'.
- 2.9 The following organisations may assist in providing qualified interpreters:
  - The British Deaf Association
  - The British Association of the Hard of Hearing
  - The National Deaf Children's Society
  - The Royal National Institute for Deaf People
  - The National Association for the Protection of Sexual Abuse of Adults and Children with Learning Disabilities
  - The Association for Speech Impaired Children
  - The Chailey Heritage Hospital, Sussex
  - The Council for the Advancement of Communications with Deaf People
  - District Social Services Offices
  - The National Association for the Prevention of Cruelty to Children
  - The National Autistic Association.

## Parents with a Learning Disability

- 1.1 Where a child who is the subject of concern has a parent/s with learning disability, workers should check whether the parent is already known to the local Learning Disability or Special Parenting Services. Contact numbers for these services will usually be obtainable from the local Health Care provider or Social Services. Further details can be found under Health Agencies.
- 1.2 If a referral is made to these services, an assessment to determine the existence of a learning disability may follow. Where special parenting services exists, early intervention is preferred, and assessment of potential or actual parenting ability may help to determine the appropriate level of concern as well as the areas in which the adult may require the most help.

## Timescale of Actions

Action to secure safety of child	Immediate
Notification of a missing child with a child protection plan	Immediate
Inform the Safeguarding Manager for a child with a Child Protection Plan where personal details have changed	1 working day
Agency reports to be received by chair of conferences	2 working days before conference
Agency reports to be shared with family or child if of sufficient understanding	2 working days before conference
Decide next course of action after initial referral	1 working day
Diary of Key worker checked for outstanding Actions / commitments by supervisor when: Notification of key worker on sick leave to designated Manager	1 working day
Notification by Children's Social Care of birth of child subject to a child protection plan	Within 2 day of birth
See child after return to home after missing (please refer to missing children procedures)	Within 72 hours of return
Review of case by Team Manager where Key worker sick more than 3 days	Within 5 days
Strategy meeting after allegation against professional	Within 5 working days
Head of Service and Safeguarding Manager informed that no Keyworker is allocated	5 working days
Initial assessment by Children's Social Care of child in need following initial referral completed	7 working days
Amendments of minutes notified to Chair of conference by relevant parties	Within 14 days of receipt

Child Protection conference arranged if no Key worker allocated 3 weeks after initial conference	Within 1 week
1st Core Group meeting from Child Protection conference	Within 10 working days
Strategy Meeting when child with a child protection plan missing	Within 7 days
Initial child protection conference following Strategy Discussion/Meeting	Within 15 working days
Child Protection conference arranged following child moving from one Local Authority (LA) to other LA	Within 15 working days
Child Protection conference minutes circulated to relevant parties	Within 15 working days
Serious Case Review panel set up after case comes to attention of Plymouth Safeguarding Children Board (PSCB) Chair	Within 1 month
Core Group completion of assessment following initial referral	Within 42 working days (within 35 days from Strategy Meeting/ Discussion)
1st Review conference arranged after Initial Child Protection Conference	3 months
Serious Case Case Review completed after case comes to attention of Plymouth Safeguarding Children Board (PSCB) chair	Within 4 months
Follow up Child Protection Review conferences	6 monthly
Plymouth Safeguarding Children Board (PSCB) Business plan	Annual

## **Guidance on Professional Differences Flowchart**

### **Introduction**

Working Together explains that the Local Safeguarding Children Board must have a:

“ quick and straightforward means of resolving professional differences of view in a specific case, for example, on whether a child protection conference should be convened: “

*3.29 Working Together*

### **Timescales**

1. The Practitioners/Professionals need to discuss or meet within 2 Working Days, if not resolved
2. The Practitioners/Professionals need to inform their respective Line Managers/Supervisors and meet as a Group within 3 further Working days, if not resolved
3. The next tier of Management or advisors need to meet within 2 working days, if not resolved
4. The PSCB Professional Differences Panel needs to meet within 2 further Working days and resolve the issue. The Panel will Report to the Plymouth Safeguarding Children Board on an Annual Basis, but extraordinary issues can be brought to the Board if needed.

### **Recording**

Each Agency will record each discussion or meeting, in their respective Child's File.

### **The Plymouth Local Safeguarding Children Board Resolution Panel**

The Panel will meet when there are at least three of the Agencies able to attend.

### **Members**

Plymouth City Council Children's Services: Nominated Child Protection Lead in Social Care or Sector Manager without Line Management responsibility.

Health: Child Protection Lead, Nominated/designated Health Professional.

Police: Representative of Community Support Unit

Other: It could be that Finance or Legal Services may need representation.

### **Decision Making**

The decision of the Panel is binding.

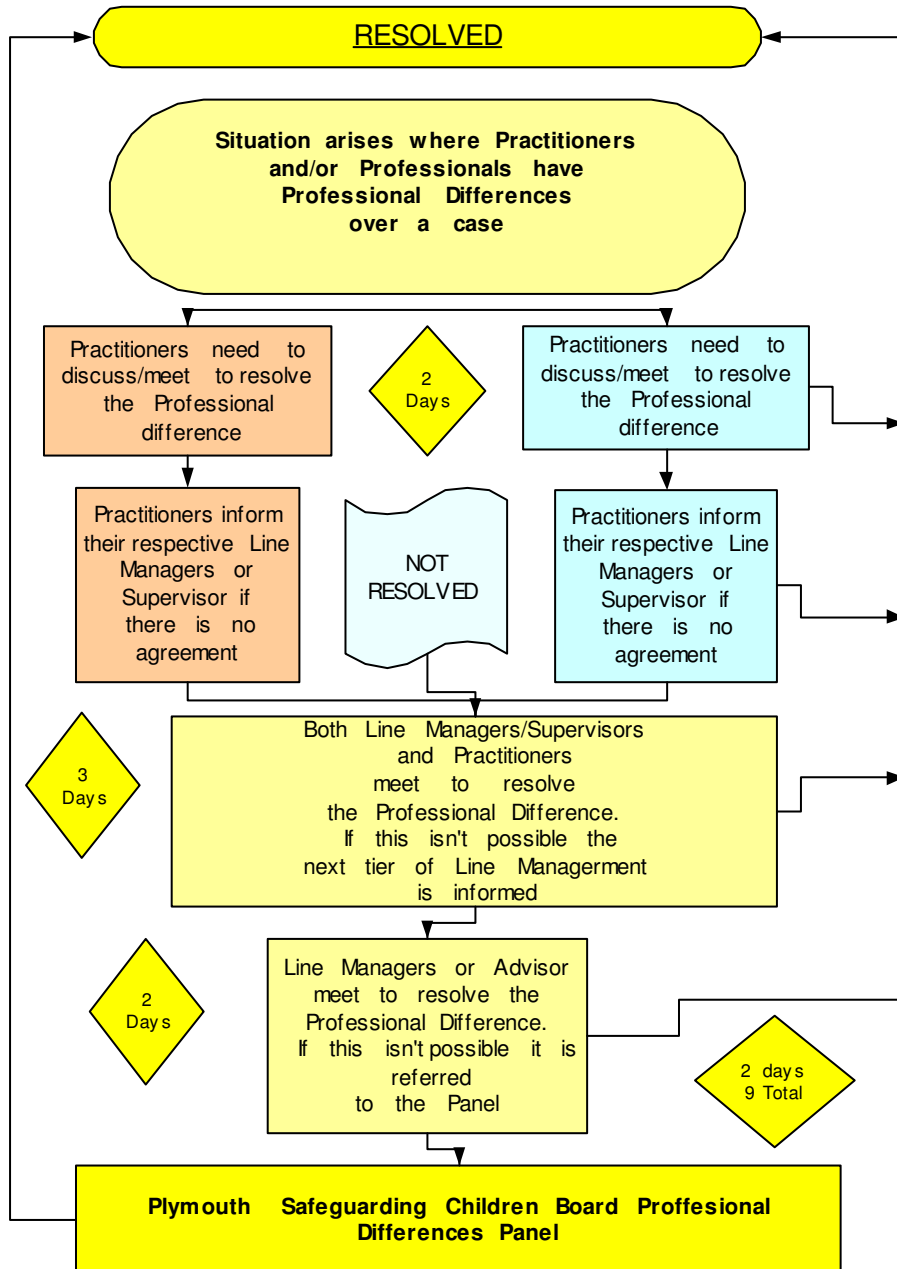
### **Reporting to the Plymouth Local Safeguarding Children Board**

An Annual Report will be prepared and presented by the Local Authority and Health Members of the Panel.

# PLYMOUTH SAFEGUARDING CHILDREN BOARD

## Professional Differences Resolution Process

Doc. Ref: PSCB CR  
 Updated:  
 05/01/2008  
 Pages: 1 of 1



## Sharing Information for the purpose of Safeguarding and Promoting the welfare of Children

- 1 This guidance is about sharing information for the purposes of safeguarding and promoting the welfare of children. Sharing of information amongst practitioners working with children and their families is essential. In many cases it is only when information from a range of sources is put together that a child can be seen to be in need or at risk of harm.
- 2 You may be anxious about the legal or ethical restrictions on sharing information, particularly with other agencies. You should be aware of the law and should comply with the code of conduct or other guidance applicable to your profession. These rarely provide an absolute barrier to disclosure. You should be prepared to exercise your judgement. A failure to pass on information that might prevent a tragedy could expose you to criticism in the same way as an unjustified disclosure.
- 3 A decision whether to disclose information may be particularly difficult if you think it may damage the trust between you and your patient or client. Wherever possible you should explain the problem, seek agreement and explain the reasons if you decide to act against a parent or child's wishes. It is often helpful to discuss such concerns with a senior colleague, designated professional, or, if you are a working in the NHS or local authority children's service your Caldicott Guardian.

### **What are the legal restrictions?**

- 4 The decision whether to disclose information may arise in various contexts. You may have a niggling concern about a child that might be allayed or confirmed if shared with another agency. You may be asked for information in connection with an assessment of a child's needs under s17 of the Children Act 1989 or an enquiry under s47 of that Act or in connection with court proceedings. In all cases the main restrictions on disclosure of information are:
  - common law duty of confidence
  - Human Rights Act 1998
  - Data Protection Act 1998.
- 5 Each of these has to be considered separately. Other statutory provisions may also be relevant. But in general, the law will not prevent you from sharing information with other practitioners if: those likely to be affected consent; or the public interest in safeguarding the child's welfare overrides the need to keep the information confidential; or disclosure is required under a court order or other legal obligation.

## Common Law Duty of Confidence

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

*The courts have found a duty of confidence to exist where –  
a contract provides for information to be kept confidential;  
there is a special relationship between parties, such as patient and doctor,  
solicitor and client, teacher and pupil;  
an agency or government department, such as Inland Revenue, collects and  
holds personal information for the purposes of its functions.  
The duty is not absolute. Disclosure can be justified if –  
the information is not confidential in nature;  
the person to whom the duty is owed has expressly or implicitly authorised the  
disclosure;  
there is an overriding public interest in disclosure;  
disclosure is required by a court order or other legal obligation.*

## Is the Information Confidential?

- 7 Some kinds of information, such as medical records and communications between doctor and patient, are generally recognised as being subject to a duty of confidence.

Other information may not be, particularly if it is trivial or readily available from other sources or if the person to whom it relates would not have an interest in keeping it secret.

For example, a social worker who was concerned about a child's whereabouts might telephone the school to establish whether the child was in school that day.

## Maintaining Confidentiality

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

## Disclosure by Consent

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

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

### Appendix 3

**Has consent been given?** You do not need express consent if you have reasonable grounds to believe that the person to whom the duty is owed understands and accepts that the information will be disclosed. For example, a person who refers an allegation of abuse to a social worker would expect that information to be shared on a 'need to know' basis with those responsible for following up the allegation. Any one who receives information, knowing it is confidential, is also subject to a duty of confidence.

Whenever you give or receive information in confidence you should ensure there is a clear understanding as to how it may be used or shared.

**Should I seek consent?** If you are in doubt as to whether a disclosure is authorised it is best to obtain express consent. But you should not do so if you think this would be contrary to a child's welfare. For example, if the information is needed urgently the delay in obtaining consent may not be justified. Seeking consent may prejudice a police investigation or may increase the risk of harm to the child.

**What if consent is refused?** You will need to decide whether the circumstances justify the disclosure, taking into account what is being disclosed, for what purposes and to whom.

### Disclosure in the Absence of Consent

- 10 The law recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others.
- 11 The key factor in deciding whether or not to disclose confidential information is **proportionality**: is the proposed disclosure a proportionate response to the need to protect the welfare of the child. The amount of confidential information disclosed, and the number of people to whom it is disclosed, should be no more than is strictly necessary to meet the public interest in protecting the health and wellbeing of a child.

The more sensitive the information is, the greater the child-focused need must be to justify disclosure and the greater the need to ensure that only those professionals who have to be informed receive the material ('the need to know basis').

### The 'Need to Know' Basis

Relevant Factors:

what is the purpose of the disclosure?

what are the nature and the extent of the information to be disclosed?

to whom is the disclosure to be made (and is the recipient under a duty to treat the material as confidential)?

is the proposed disclosure a proportionate response to the need to protect the welfare of a child to whom the confidential information relates?

## Young People who misuse substances

Young people who use substances / confidentiality.

Young People refers to any child and young person under the age of 18 years.

The use of drugs and alcohol by young people cannot in itself be seen as indicative of having caused or causing significant harm. It is essential, however, to recognise that substance use by young people can be potentially harmful.

Holistic assessment of all the young person's needs should be undertaken in order to determine risk. If substance use is identified as being a significant issue then those agencies or practitioners with specialist knowledge and skills (in relation to substance use) should be used for consultation and / or may take part in the assessment as appropriate.

Questions a Professional may find useful when conducting an assessment:

### **Young Person's Perspective on Drug Taking:**

Is the young person concerned about her / his substance use or should they be?  
Is the young person having difficulties in perceiving or achieving a life without using substances?

What does the young person see as the reason for using substances?

What is the young person's perspective of their substance use?

Other people's perspective of her / his substance use?

What help does the young person want, if any, generally and specifically to substance use?

What are the young person's plans and goals for the future?

Who would the young person like to discuss these problems with?

Who would the young person not want these problems discussed with and why?

### **Social Situation:**

What is the young person's relationship like with those she / he lives with and others such as parents / carers or other significant people in her / his life?

Do the young person's parents / carers or those they live with use substances. How does this affect him / her?

Is the young person in contact with siblings? Do any of them have problems with substances?

Is the young person happy with his / her accommodation and if not what are the reasons?

How much a week does the young person spend on substances and how do they finance their substance use?

What does the young person do with their free time?

Is the young person sexually active and if yes is this linked with their substance use?

Does the young person have any fears? What happens if they feel stressed?

How do they feel about school / college / work? Are they disaffected from school or unemployed? If yes for how long?

Have they been excluded from school and if so for how long and why?

Has the young person been in trouble with the Police and if so was this connected with substance use?

## Assessing Child Protection Concerns:

Is the identified substance use unusual for a person of this age?

Does the young person have a mature understanding of the level and type of their substance use?

Is the substance use life threatening or seriously detrimental to health?

Is the substance use becoming increasingly chaotic or dangerous?

Does the young person have complex problems that may put them at risk of significant harm as a direct result of using substances?

Is the substance use leading to crime or exploitation by others?

Are there non-substance related criteria for consideration of the child protection procedures?

Are there any mental health problems?

Does the young person report any self harm or suicidal feelings?

Is the young person, if a female, pregnant or likely to become pregnant as a result of their substance use?

The above is not an exhaustive list and where there are concerns, consultation should take place with professionals who have the knowledge and skills.

## Substance Misuse

### General

A range of terms and definitions can be used in the area of drugs and alcohol. In this document the term 'substance use' refers to the use of alcohol, illegal drugs, illicit or inappropriate use of prescription drugs and volatile substances.

### Parents and Carers who use Substances

The use of drugs or alcohol by parents / carers does not automatically indicate a risk to children. It's important to be aware of the prejudices held and the assumptions made in this area of work. The starting point for practitioners should be that the majority of carers who use substances can and do provide for and meet the needs of their children. It is important however to recognise that some parents / carers substance use results in significant risk and / or harm to their children.

Assessment needs to be undertaken within the 'Framework for Assessment' but in assessing substance use account needs to be taken of the pattern, meaning and role that substances play in the lives of the parents / carers, together with any resultant behaviours that may place children at risk.

### Key questions underpinning the assessment are:

What role does the substance use have on the family life?

How does this actually impact on the ability of parents / carers to meet the needs of their children?

Where drug and / or alcohol use has been specifically identified as a significant issue, a comprehensive assessment of the relationship between the substance use and childcare is required. Close collaboration between child care and adult practitioners (drugs and alcohol) is essential in order to undertake full and informed assessments of any risks, needs and to consider how to address any needs identified including that of protection, in an integrated and a co-ordinated way.

### Action

As with other investigations and assessment a decision will have to be made whether a child in need (Sec. 17) or a child at risk (Sec. 47) enquiry needs to be conducted. Consideration may also have to be given as to whether there is a need to twin-track these enquires.

For further guidance on procedures and conferencing see the appropriate sections.

### The Pattern of Substance Abuse by Parents:

Is there a substance-free parent or a supportive partner?

The type, quantity and method of administration of substances?

Whether substance use is relatively stable or chaotic, such as swings between states of severe intoxication and periods of withdrawal and / or multi-substance use including alcohol?

Do the levels of care change significantly according to usage?  
Is there any connection between the levels of parental care and a changing pattern of substance use?  
Is the child present, eg. a witness when substances are used or administered?

### **Accommodation and Home Environment:**

Is accommodation adequate for the children? If not, on what basis and is there a link to carers substance use?  
Are the parents ensuring that rent and bills are paid?  
Does the family remain in one district or move frequently and if so, why?  
Are other substance-users sharing the same accommodation?

### **Provision of Basic Necessities:**

Is there adequate food, clothing and warmth for the children?  
Are the children attending school regularly?  
Are the children engaged in age-appropriate activities?  
Are the children's emotional needs being adequately met?  
Are the children assuming any responsibility for caring for themselves, parents or other children beyond normal expectations for their age?

### **How the Substances are procured:**

Are the children being left alone whilst the parents are procuring substances?  
Is there evidence that children are being put at risk whilst parents procure substances?  
How much are the substances costing and how is the money obtained?  
Are the premises being used for selling substances or prostitution?  
Are the children aware or involved in this?  
Are the parents allowing their premises to be used by other substance users. What evidence is there that this is putting the children at risk?

### **Health Risks:**

Where are the substances normally kept? Do the children ever have access to the substances?  
Are the parents injecting substances? Are the needles shared? How are they disposed of? Does this pose any risk to the children?  
Is anyone else in the house injecting, or using the house for injecting?  
Is there any danger of younger children accidentally having access to the parents' substances or other children experimenting with them?

### **Families Social Network and Support Systems:**

Do parents and children associate primarily with other substance users, non-users or both?  
Are relatives and friends aware of the substance use? Are they supportive?  
Will parents accept help from the relatives and other professional / voluntary agencies involved?

### **What are the Parents' Perceptions of the situation?:**

Do the parents / carers see their substance use as harmful to themselves or their children? Would they like to do something about their substance use? Are they aware of services available to support ending or managing their substance use?

### **When is Statutory Intervention necessary?:**

Automatic intervention on the basis of substance use is likely to deter contact. Does the situation require intervention via an order of the court either to protect the child or secure an assessment?

Do the parents constantly place their own needs before those of their children?

The above factors will also apply when the concern exists about substance use in pregnancy. Additionally, however, the implications for the unborn child with regard to the substance taker's habit will also need to be assessed. It is essential in such circumstances that specialist advice is sought, as many misconceptions exist about the effect of substances on the foetus.

Are the parents / carers aware of the child protection processes, procedures and the thresholds for statutory intervention?

## **Notice to staff using a paper copy of this guidance**

**The Child Protection Procedures page of The Plymouth Safeguarding Children Board holds the most recent and approved version of child protection guidance.**

**Staff must ensure they are using the most recent guidance.**

**The most recent Guidance is posted on the Local Safeguarding Children Board Webpage ( the address is at the end of this document )**

**[www.plymouth.gov.uk/localsafeguardingchildrenboard.htm](http://www.plymouth.gov.uk/localsafeguardingchildrenboard.htm)**