

safeguarding children in devon

Welcome

Welcome to the September 2016 version of the magazine. If you have any thoughts, views, suggestions get in touch with your ideas and watch this space for new ways to make the magazine most useful in practice ... magazine@dialogueltd.co.uk

The magazine provides basic information on all the areas you need to know to meet the training requirements of the NHS Intercollegiate document and Working Together. Each article will provide a short introduction with links to further reading if you want to find out more, or links to local services should you need to speak to someone.

We check all the links at the time of going to press, but if you spot a mistake let us know. We update the magazine termly, so do make sure you have the latest issue, available at the DSCB website. For a summary of what's new in this issue see the next page.

We hope you find it useful,

Sally Yeo, DSCB

John Woodhouse, dialogue

Contents

Early help or MASH...?	3
Threshold tool	3
Early help & MASH	4
Top tips for a MASH enquiry	4
Think Family.....	5
Risk and uncertainty.....	5
Information Sharing ★	6
Forms of abuse.....	7
Identifying abuse.....	9
Child protection process.....	9
Escalation policy.....	11
Private fostering.....	12
Assessing risk in unborn children.....	13
A Child's First Year.....	13
Attachment and vulnerability.....	14
Thematic Review - Infants ★	15
Adolescence.....	16
Young Carers.....	17
Emotional and mental wellbeing.....	19
Young people, drugs and alcohol.....	20
Online safety and abuse.....	21
Missing children.....	22
Recognising and Responding to Sexual Abuse.....	23
Thematic Review – Child Sexual Abuse ★	24
Child Sexual Exploitation and MACSE.....	25
Friends and gangs.....	27
Children in care.....	28
Leaving care.....	28
Youth Offending.....	29
PREVENT agenda and CHANNEL process.....	29
Disability.....	30
Fabricated or Induced Illness (FII).....	32
Listening to children.....	33
Competence.....	33
The Mental Capacity Act.....	34
Advocacy.....	34
Working with men.....	35
Culture and religion.....	36
Honour based violence.....	37
Female genital mutilation ★	38
Domestic violence and abuse.....	39
Parental mental ill health.....	42
Disguised Compliance ★	43
Poverty.....	44
Case study.....	45
Parental substance misuse.....	47
Parental learning difficulty.....	48
Safety at work / LADO's and Whistleblowing.....	49
Culture of openness.....	51
Recording.....	51
Chronologies.....	52
Genograms.....	53
Courts.....	54
Focus on Serious Case Reviews.....	55
Serious Case Reviews – The national picture ★	56
Serious Case Reviews – What can we learn?.....	59



produced by **dialogue**, a training and practice consultancy
dialogue provide training and consultancy for the DSCB
contact us at magazine@dialogueltd.co.uk



What's changed in this edition?

We continue to welcome your feedback as this informs development of the next edition of the magazine. In this edition we have focused more on how reviews undertaken in Devon should be informing our work, with serious case reviews being the area of focus.

We have updated / added the following sections (look for the star at the top of the page):

- **Information sharing (p.6)** – this section has been updated in light of new research which suggests that issues with information sharing are linked to organisational culture.
- **Thematic reviews** – this edition adds the summaries of two thematic reviews:
 - **Infants (p.15)** - looking at the specific risks of 0-1 year olds
 - **Child sexual abuse (p.24)** - looking at professionals approaches to dealing with child sexual abuse
- **Female Genital Mutilation (p.38)** – this section has been updated with recent statistics from new research.
- **Disguised compliance (p.43)** – this new section looks at what disguised compliance is and how to change practice to identify and challenge it.
- **Serious case reviews – the national picture (p.56)** – this new section provides a summary of the latest national analysis of serious case reviews and looks at key findings.
- **Serious Case Review summaries (p.57)** – Updated to explore the latest serious case review published by the Devon Safeguarding Children Board and consider the ways in which we can challenge our practice. Also includes an overview of a serious case review undertaken by another LSCB, but where the family lived in Devon for a period of time.

Learn more...



Look for this icon. It indicates training courses you can access to learn more about the subject.

There are also [hyperlinks](#) throughout the magazine to source documents for further reading.

Begin with the family...

Bringing up children is a challenging but rewarding task. None of us get everything right all the time, and some of us need additional help to help our children achieve their potential. Sometimes this is because the child has additional needs, sometimes it is around our abilities as people and parents, sometimes it is the situation we live in that makes things hard.

At these points Devon offers additional support, through early help, the special educational needs or disability pathway, or safeguarding work. This document helps highlight some of the issues people may face and the factors that might help or hinder our work with them.

Throughout all of this we must work to ensure we keep children and their parents at the centre of what we do. The more complicated the family situation, the harder this can be to achieve.

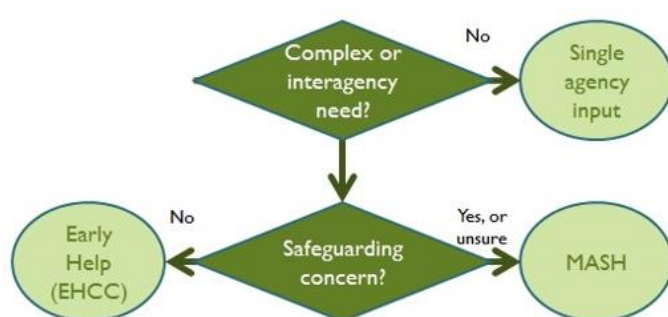
The best people to keep children safe are usually those who know them best, often their parents. In almost all circumstances we should ask for their consent to work with them, unless to do so would place a child at additional risk of significant harm or the young person has the age and understanding to decide for themselves.

This should be the starting point, working to understand the problem from the children's and parents' perspectives, then working out who is best placed to support the family with a well constructed plan.

We hope this magazine helps you in understanding the needs, forming a plan and working with families to achieve change for their children.

Early help or MASH...?

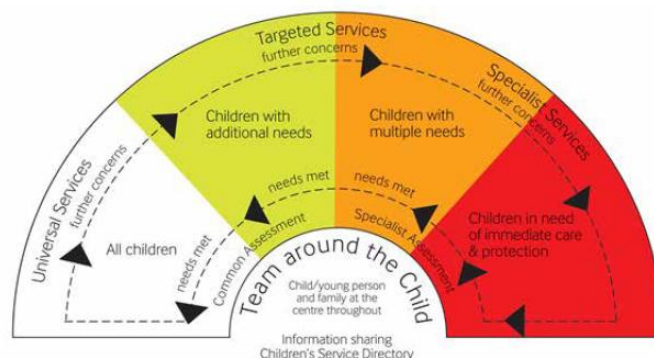
We all have a responsibility to work together to improve children's lives. Safeguarding concerns always need to be considered by the Multi Agency Safeguarding Hub:



Threshold tool

This tool is designed to help us understand the needs of Devon's children, to think through who should be involved and to clarify when to take action. It has examples of need at each level to help you determine how to respond.

Continuum of needs (commonly known as The Windscreen)



[Download](#) the tool from the DSCB website to help you think through needs and decide how to respond. Watch our short video on the site to see an example of how to apply the tool in practice.



See our video on **How to use the threshold tool**

Early help

Early Help is about making sure that children living in Devon are safe, healthy, happy and well educated. It comes into effect when two or more services work together with the child and their family.

If we do this well, fewer children should need statutory risk assessments.

Children should be healthy, safe and cared for, with the best start in life, are able to make the most of opportunities throughout their childhood and adolescence so that they become responsible adults who will be able to care for their own children – the next generation.

We know that the needs of parents and the family environment significantly impact on the life chances of the child. Any plan needs to take account of the whole family's needs.



You can learn more about early help on our [elearning course](#)

MASH

If you have a safeguarding concern on a child not already open to children's services, you should complete a [written enquiry](#) to the multi-agency safeguarding hub (MASH). You'll need to think about getting consent to this – there's more on this and [guidance](#) on filling in the form on the DSCB website. If a child is in imminent danger or needs urgent accommodation, call on 0345 155 1071.

Your enquiry will be considered by MASH's referral coordinators and decision-makers with a written response within 48 hours.

Top tips for a MASH enquiry

- Consent should be obtained from the family to make the enquiry, unless it is a child protection matter and to seek consent would put the child at further risk of harm
- The enquiry form should be completed as fully as possible, including:
 - basic information about child's name and date of birth
 - family details including dates of birth and family household composition
 - ethnicity and language of children and parents
 - identification of adults with parental responsibility and surnames if they are not the same as the parents
 - address and telephone number of the family and carers and any other significant adults and GP details
 - schools or early year settings attended
 - name of key professionals, such as health visitors, GP and any health professionals
 - nature of the concerns including any family history known or available to referrer.
- Enquiries made by telephone should be followed up with a completed enquiry form within 48 hours – this helps ensure that the information recorded in the MASH is the same as the information you are providing.
- As a professional you need to be clear why you are referring it the MASH, and why the enquiry is being made now.

Think Family

The Children Act 2004 states that all services should be working around the needs of children and their families, and that parents / carers needs should not be seen in isolation of the child's needs.

The presence of parental needs does not necessarily mean that their parenting ability will be impacted, but there is a need for agencies to work together to make sure this is the case. When considering the impact on the children there is also the need to determine whether the child is a young carer.

To make sure that this happens within defined timescales there is a need for adult's and children's services to work closely together.

The Think Family Protocol sets out what needs to happen to achieve joint assessments in Devon, in essence:

- Risk assessments undertaken by adult services consider the risks to any children in the home
- Clear communication between agencies
- Understanding of the impact of parental issues on parenting
- Services that work together and understand each other's thresholds and timescales

The protocol is clear that where joint assessment is required, Children's Services will be the lead agency but work closely with other agencies with close planning from the outset.



Read the **Think Family Protocol**

Book to attend the Think Family training on the **DSCB website**

Risk and uncertainty

We are constantly working in areas of risk and uncertainty. We are required to make professional judgements based on the information available to us, whilst acknowledging how our own value base may be impacting on those decisions. We also remain all too aware that the wrong decision may have significant consequences for all involved.

Morrison (1990) referred to the concept of professional dangerousness:

The process whereby professionals involved in child protection work can behave in a way which either colludes with or increase the dangerous dynamics of the abusing family.

How therefore do we ensure that we are addressing risk and not colluding? Human nature is such that we will always try to see the best in a situation (rule of optimism), however we should look for the strong evidence to support this view before acting on it.

Munro (2011) stated:

Building strong relationships with children and families with compassion is crucial to reducing maltreatment, but trust needs to be placed with care, and 'respectful uncertainty' towards families, and interest and curiosity in their narratives, needs to be part of the practice mindset.

In other words, in order to manage the risk and uncertainty, as professionals we should be asking 'what if ...' and 'what does this mean for the child'.

Information Sharing



A key factor in many serious case reviews is that a good standard of practice has not been in evidence when professionals have been recording, sharing, discussing and analysing information in order to make an assessment of the needs of a child or the risks to the child. It is crucial to understand the significance of the information shared and to take appropriate action in relation to known or suspected abuse or neglect. Often it is only when information from a number of sources has been shared that it becomes clear that a child has suffered, or is likely to suffer, significant harm.

In deciding whether there is a need to share information, you need to consider the requirements on you including:

- Whether the information is confidential
- If it is confidential, are there grounds for sharing it without getting consent first?

Usually you should always get consent before information is shared, unless:

- there is evidence that the child has suffered, or is likely to suffer, significant harm;
- there is reasonable cause to believe that a child has suffered, or is likely to suffer, significant harm;
- there is evidence to suggest that if you sought consent a child or adult may be harmed;
- there is evidence that action may need to be taken to prevent or detect a crime meaning that it may not be appropriate to ask for consent.

If you decide to share information then you must record your decision, the context in which the information was shared and the reasons for your decision.

If none of the three criteria above are met, **you must seek consent**.

Consent can be either explicit or implicit and should always be informed (i.e. the person giving consent knows why information is being shared, what information will be shared and what the implications are).

Implicit versus explicit consent: A GP refers a patient to a specialist with their agreement. The GP will assume that the patient has given **implicit consent** to share information with the specialist by agreeing to the referral. A family support worker starts working with a family. At the start of their work they go through a form with the family to get written agreement as to which other professionals they can speak with (e.g. school, health visitor). This is **explicit consent** to share information with these professionals.

[Research \(2016\)](#) recognises that information sharing is not necessarily easy with issues including:

- differing understanding of vulnerability leading to concerns not being recorded / shared
- over reliance on the positive picture that the families paint of themselves
- fears over the risks to the relationship with the family

Cultures of organisations therefore can have a significant role to play in whether information is shared or not – what do you do when it is not child protection – do you always seek to share information? What stops you and why?

For further information...

- See the SWCPP pages relating to [Information sharing](#) and [Consent and Confidentiality](#)
- Read the government guidance – [Information sharing: Advice to practitioners providing safeguarding services to children, young people, parents and carers](#)
- See 2016 research [Information sharing to protect vulnerable children and families](#).

Inter-agency working

Throughout Working Together 2015 the emphasis is on inter-agency working, from the point of early help through to the implementation of child protection plans.

Safeguarding is everybody's responsibility, and key to this is agencies working together towards a common goal.

In his progress report following the death of Baby Peter, Lord Laming (2009) stated:

Relationships are crucial; it's not about structures, it's about making it work out there for children.

We are all in roles which require us to build relationships with colleagues, peers, families and children. Good inter-agency working uses these skills and means that judgements and decisions are better informed.

For example, when considering whether a three year old child is at the right developmental level for their age, if you have a relationship with the health visitor then you can discuss your observations linked with their professional knowledge and the mutual knowledge of the family to form an informed view about what you are seeing.

Good inter-agency working should also include an element of challenge of colleagues. Such challenge should be constructive, but ultimately the presence of challenge should ensure that decisions are made on a firm foundation of evidence (therefore reducing the risk of decisions being made on an over-optimistic viewpoint).

Forms of abuse

Abuse takes many different forms and can mean different things for different children.

The links below provide specific information about signs and symptoms or abuse, but the key question is **what am I seeing and what does it mean for this child?** Some professionals may see certain children on a regular basis and be able to tell when something is wrong, others may have to rely on a more general knowledge of child development to know when to be concerned.

Many serious case reviews have identified the following themes:

- Start again syndrome – although there has been previous involvement with the child, this is not taken into consideration when considering new information
- Silo thinking – think around the problem, rather than just from the point of view of your agency. Sometimes the biggest risk to the child is not from the presenting issue, but from other issues in the background. For example the child has a known history of being physically abused, but that they are also being neglected is not picked up as everyone is focusing on the physical abuse.

Neglect

Neglect is the most prevalent form of abuse in the UK with almost half of all children being on child protection plans for neglect. The NSPCC suggest that 1 in 10 children have experienced neglect.

Neglect can be life threatening and should be treated with as much urgency as other categories of abuse.

We often intervene later with neglect, sometimes because no single incident acts as a trigger, instead neglect builds up over time. We need to understand the cumulative effects of neglect and actively review the concerns to understand the level of harm caused.

Emotional abuse

The effects of emotional abuse can also be cumulative – use chronologies to track this. Emotional harm can be present in all forms of abuse, and can have significant long term effects on a child's mental health, education, future expectations and ability to relate to others. As with neglect, emotional abuse needs to be proactively considered to ensure that the need for a referral can be identified sooner.



Emotional Abuse & Neglect training at the **DSCB website**

Sexual abuse

The impact of being sexually abused can be lifelong, with estimates suggesting that child sexual abuse cost £3.2bn in the UK in 2012 (in terms of service provision to help survivors through their experiences). Research has also identified that professional's confidence in dealing with cases of sexual abuse is lower than when dealing with other forms of abuse, so it is important that you get help and support as needed. The reach of offenders has increased significantly with the internet: harm can be inflicted from a distance and with relative anonymity. Ensure questions on internet safety are considered.



Child Sexual Abuse training at the **DSCB website**

Physical abuse

Physical abuse includes inappropriate chastisement and premeditated abuse. Where parents have smacked children it will be abuse where the child has been injured/bruised or an implement used.

As part of growing up children will get bruises and other injuries, however these are more likely in some areas than others, for example most accidental bruises are seen on bony parts of the body (e.g. shins, knees and elbows). Children can also have fractures of certain bones (e.g. rib) without any bruising.

Bruises cannot be aged accurately, with research suggesting that 50% of people who aged a bruise by its colour were wrong with their estimate.

With any injury, if you are uncertain the recommendation is that medical advice is sought, usually from a doctor or other appropriately trained member of medical staff.

For further information on the types of abuse

- Look at [Working Together 2015](#) for more information on definitions
- Refer to SWCPP for more information on [definitions of abuse / signs and symptoms](#)
- If you are a medical practitioner look at the [NICE guidelines on when to suspect child maltreatment](#)
- For further information about all types of abuse search the [NSPCC website](#) for general information and specific themes.

To speak to someone about concerns about a child being abused contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Identifying abuse

Often the first indication is your general feeling that something is not right. It is important that this is recognised for what it is and that it is followed by an active process of enquiry in order to work out why you feel something is not right.

This process should involve looking at what you know about the child and what it is about their current presentation that is causing concern. Once you have established this then you can talk with your line manager / designated lead or talk to MASH about your concerns.

Child protection process



When you have a concern about a child being at risk of harm you make a referral to MASH. If the referral relates to a potential child protection matter, then a strategy meeting will be called (if this is not possible due to time constraints then as a minimum a telephone discussion must be had).

The purpose of this meeting is to consider the referral, share information about the child and the family in a confidential environment and make decisions about whether children protection enquiries are required, and what the plan for these enquiries should be. All strategy meetings should as a minimum have Police, Social Care and health with other agencies attending as appropriate. You may be asked to attend a strategy meeting and you will be expected to share information held by your agency as well as taking an active role in the discussions about what happens next.

Child protection enquiries

Also known as s47 enquiries (after the relevant section of the Children Act 1989), Social Care will be the lead agency for undertaking and completing the assessment that forms the backbone of the enquiries. All agencies who have involvement with the child and family will be expected to contribute to the assessment. The assessment will look at all the children in the household and assess level of need and risk.

The outcome of child protection enquiries can be as follows:

- Concerns not substantiated – i.e. there is no information to back up the initial concerns. This does not mean that other needs will be ignored, but that there is no continuing need for the child protection process
- Concerns substantiated but child not suffering or likely to suffer significant harm – i.e. something happened that meant the child was harmed or at risk of being harmed, but the carers have taken measures that will protect the child (e.g. the

abuser has left the home). As with the previous point this does not necessarily mean that the child does not have needs that require a service, just that there are felt to be no ongoing child protection matters

- Concerns substantiated and risk of child suffering or likely to suffer significant harm – i.e. there are concerns that there is ongoing risk to the child which needs agencies to act together to reduce the risk and bring about change. This outcome will lead to a case conference being called.

If the decision by Social Care is that there is no need for a case conference but another agency disagrees, then this decision can be challenged and a conference requested.

Child Protection Case Conference

The case conference involves the family and all the professionals involved coming together in a meeting chaired by a person independent of the case. At the meeting, everyone concerned with the child's welfare, professionals, parents, carers, young people and children will be asked to contribute their views and what they are worried about, what they feel is going well and what needs to happen for the concerns to reduce.

If you are asked to attend a child protection case conference you will be expected to know the information that your agency holds and submit this in a written report at least 3 days before the conference. At the conference you will be required to present this information verbally and then, having listened to the other information available to the meeting, form a view about whether there is a continuing risk of harm to the child.

Where the decision is that there is continuing risk, a child protection plan will be drawn up, requiring the family and involved agencies to work together to reduce the risks to the child and bring about long term change.

If the decision is that there is no continuing risk, a plan may still be drawn up so that support is provided to the family, but the case will drop out of the child protection process.

Core Groups

Where a child is made subject of a child protection plan, a core group consisting of the child (if old enough), parents and main agencies will be drawn up. The core group will meet for the first time within 10 working days of the initial conference and then every four weeks thereafter.

Chaired by the social worker, the core group is responsible for making sure that the plan is put into action and everyone works together to reduce the risk.

If the core group feels that the risks are increasing, or that there is no change happening for the child they can request that a review conference is held early to formally review the child protection plan.

If you are asked to be part of a core group there is an expectation that you will be actively involved with the family in looking to reduce the risk and effect change.

Review Conferences

Review conferences will be held at regular intervals for all children on child protection plans, and they should be no more than 6 months apart.

The purpose of the review conference is to consider what has happened in the time since the last conference and whether

progress has been made towards reducing the risk to the child.

The information the conference hears will determine whether the plan should continue for a further period of time, the plan should come to an end (if the risks have been reduced to a satisfactory level and there is lasting change) or whether the case should be escalated and further action taken (e.g. should there be an application made to court in order to keep the child safe).

As with the initial conferences, as an attendee you will be expected to provide an update of your agency's involvement since the last meeting and form a view as to whether the plan should continue or not.

For further information...

- See [Working Together 2015](#)
- See the [South West Child Protection Procedures](#).



Book Child Protection training on the **DSCB website**

Devon is currently developing a strengths-based planning and review model for child protection planning.

More information will be released to all agencies soon and there will be opportunities for learning more and attending training on the new model towards the end of 2016.

Escalation policy

Occasionally situations arise when a professional feels the decision made by another is not a safe decision.

The safety of children is the paramount consideration in any professional disagreement. It's crucial to resolve this with due consideration to the risks that might exist for the child.

All workers must feel able to challenge decision-making to promote the best multi-agency safeguarding practice.

There are 4 stages:

1. Talk it through with your manager
2. Talk to the person you disagree with (and the social worker if allocated)
3. Raise the issue manager to manager
4. Raise the issue through the named/designated safeguarding representative
5. Refer to the chair of the LSCB

As a general rule – if you remain worried, take it further until you are satisfied the child is safe or someone has taken this on.

For further information...

Read the [escalation policy](#) on the DSCB website

Private fostering

Private fostering is when it is planned for a child or young person under 16 years old (or 18 if they have a disability) to be looked after for a period of 28 days or more by someone who is not a close relative, guardian or person with parental responsibility. Close relatives include parents, step-parents, aunts, uncles and grandparents.

People become private foster carers for all sorts of reasons. Private foster carers can be a friend of the child's family, or be someone who is willing to care for the child of a family they do not know.

There are a variety of reasons why a parent may be unable to care for their own child on a short or long term basis and a private fostering arrangement can be a positive response from friends and the local community to a family in need of support. However, any child separated from their parents is potentially vulnerable and therefore workers and volunteers all have responsibilities to ensure the alternative care they receive meets their welfare and safety needs.

By law, Devon County Council (DCC) must be told about all private fostering situations. The child's parents, private foster carer and anyone else involved in the arrangement are legally required to inform Devon County Council.

It is then Devon County Councils legal duty to make sure all private fostering arrangements are safe for the child or young person. Once informed of the arrangement DCC will check the suitability of private foster carers, make regular visits to the child or young person and ensure advice, help and support is available when needed.

Information for Professionals

Private foster carers are legally required to notify Devon County Council but many still don't know that they have to. This means the necessary arrangements to ensure the child or young person's welfare is safeguarded are not made. Workers from all agencies need to help by ensuring they are proactive in identifying and notifying the council of private fostering arrangements that they are aware of.

If you know a child or young person is being privately fostered and you think we are unaware please notify DCC or support the parent/carer to do so.

For further information on Private Fostering

- See the [South West Child Protection Procedures](#)
- Watch a film on private fostering: [Somebody Else's Child](#)
- Download our [Private Fostering Leaflet](#)

To speak to someone about private fostering...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Assessing risk in unborn children

Young babies are particularly vulnerable to abuse and work carried out in the antenatal period can help minimise harm if there is early assessment, intervention and support. Be aware of:

- Worries about either parent's current behaviour, e.g. known mental health concern or substance misuse
- Concerns either parent/carer may not be able to care for the baby to an acceptable standard, e.g. significant learning difficulty, previous neglect or other children subject to child protection plans/taken into care
- The behaviour of others (including fathers) may pose a threat to the unborn baby, e.g. domestic abuse or known allegation or conviction for offences against children under 18
- The impact of one parent's behaviour on another may reduce care for the baby to an unacceptable standard
- Known vulnerabilities in the parent's lives, e.g. looked after history, poor home conditions, temporary housing
- Teenage or young parents

Waiting to see if things improve creates delay and increases risk to babies. If you suspect the child's health or development will be affected when born refer to MASH by 12 weeks gestation, or as soon as possible thereafter to give an opportunity for the services to have an impact with the parents.

A Child's First Year

Children develop significantly in the first year of their life, however they are also arguably at their most vulnerable during this period. They are completely reliant on the adults around them to

meet all of their care needs (both practical and emotional) and cannot necessarily get out of the way if there is a problem (e.g. physical abuse).

What should happen in the first year?

Remember that this is a guide and all children will develop at different rates – the following is taken from a general guide published by the NHS.

1-4 weeks	Baby will enjoy looking at faces and start to recognise their parents They may be startled by sudden noises
4-12 weeks	Baby will start to smile and respond to sounds (4-6 weeks) Baby will start to lift their head while lying on their front (4-12 weeks) Some vaccinations should take place in weeks 6-8
3-6 months	Baby will start to reach out for objects and develop the ability to hold objects Further vaccinations are due in months 3 and 4 Baby will enjoy making new and different sounds
6 months	Baby will learn to pass things from one hand to another Baby can start to be introduced to solid foods
6-9 months	Baby starts to be able to sit without assistance and may start to crawl, becoming more mobile moving on to pulling themselves upright (using furniture) The first milk teeth will start to appear (teething) At 7 months baby can start

	to respond to quiet noises if not distracted and will also respond to their parents voice
9-11 months	Baby learns to drop things by letting go or passing it to someone Over the next 8 months baby will start trying to walk on their own
11-12 months	Baby will enjoy trying finger foods Baby will respond to their own name

Every child at this age should have a Health Visitor and they are a good point of contact if you want further information about whether a child is meeting their milestones. If a child is not meeting their milestones then this **may** be a cause for concern and further advice should be sought.

Attachment

Attachment is an individual process for all children and an indicator of the ability of the parents to respond to the child's needs. In summary, children should have a secure attachment to their primary care giver. Evidence of secure attachment can be seen in an infant's reactions, for example (note, the term mother is used for example purposes only):

- Child is distressed when mother

leaves

- Avoidant of stranger when alone, but friendly when mother present
- Positive and happy when mother returns
- Will use mother as a safe base to explore their environment.

Where a child is not securely attached they may not seek comfort when distressed, or conversely may be overly clingy whilst rejecting direct interaction from their care giver. If children display these behaviours then further assessment is required to determine whether there are unmet needs or some other underlying issue.

Vulnerability

In their first year of life there are many risk factors present. Of particular note from serious case reviews is the risk associated with co-sleeping (baby sharing a bed or sofa with parents), parental substance misuse and risk of physical harm as a result of an adult's stress due to the baby's continual crying. Co-sleeping risks are particularly high when parents have used drugs or alcohol before going to sleep and where the parent and baby are sleeping on the sofa.

As professionals there is a need to be hyper-vigilant to any potential signs or symptoms of abuse in very young children.

For further information on child development

- See the NHS Choices website – [Birth to Five Development Timeline](#)
- See the NSPCC booklet – [All babies count: Spotlight on drugs and alcohol](#)
- See the NSPCC booklet – [Core-info: Bruises on children](#)
- See the NSPCC resource on the mental health needs of babies and young children in care – [Looking after infant mental health: our case for change](#)

To speak to someone about concerns about a young child ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Bruising in non - mobile infants is an accepted red flag for abuse. The prevalence of bruising in non-mobile infants is less than 1%. The rate of bruising increases as development progresses with 17% of crawlers and cruisers and 50% of walkers displaying some bruising.

The distribution and extent of these bruises is characteristic and patterns of abusive bruising in mobile children (as well as non – mobile) are well established. Practitioners must maintain their professional curiosity regarding the alleged causes of these bruises recognising that parents/carers may present them to agencies but that this is not necessarily protective nor does it indicate innocence.

Whilst bruises can and will occur in non-abusive situations you should always ask the question as to whether this could be an indicator of abuse – you must get such bruising checked out and discuss it with your manager / lead.

Thematic Review - Infants



Following the DSCB Serious Case Review Subgroup seeing several cases involving infants with similarities in their circumstances, a thematic review was completed in 2016.

Well recognised risk factors were present in the six cases reviewed:

- Mental health disorders
- Young parents
- Drug and alcohol use
- Poor family support including estranged families
- Domestic abuse

- Parental criminality
- Previous concerns in relation to older siblings
- Concerns about abuse (including child protection planning)
- Adoption of older siblings due to child protection concerns.

Well recognised themes also emerged relating to professional's approaches:

- Over optimism
- Lack of curiosity and challenge
- Lack of knowledge around the significance of bruising or minor injuries in young children
- Poor communication and silo working
- Poor recording.

Sentinel injuries

Research has shown that around 25% of infants presenting with a serious head injury will have been in contact with health services previously because of a "minor" injury. These are known as sentinel injuries and represent an opportunity to intervene in order to prevent further injury following the well-recognised escalation of violence in these families.

See the whole picture

Consideration of the historic injuries to older siblings of the index case should be included during the assessment of risk when an infant presents with an injury.

The full summary (5 pages) can be found at:

<http://www.devonsafeguardingchildren.org/documents/2016/06/dscb-thematic-review-infants.pdf>



Adolescence

Adolescence brings with it unique problems and issues, with both internal pressures around perceived expectations of others and external pressures to conform, whilst developing as an autonomous individual. Serious case reviews often identify that older children did not receive a service as they were seen as resilient, obstructive, not willing to engage. It is however important that we do not label older children and that we rethink how we work with them to ensure that they remain safe from harm.

Communicating with adolescents

Text speak, different meanings for words, acronyms, not really speaking at all. These are all often cited as issues for adults not feeling able to have a conversation with adolescents. Coupled with this is that adolescents often behave in ways that may it difficult for us to give them what they need the most, acceptance and consistency. How often do we hear parents say that everything descended into an argument?

Using basic principles which we already know, we can have a conversation with adolescents:

- **Whose agenda are you following – is what's important to you important to them?** An example of this is research with victims of sexual exploitation which identified that the person who was identified as being most supportive was the one who did not go straight in with talking about sexual exploitation with the young

person, but instead wanted to talk about what was bothering the young person (one example was a young person being bullied at school)

- **Use open questions.** Although this seems common sense, often we get caught up in saying things like "Did you do ...?" which shuts the conversation down
- **Are you lecturing / telling them what to do, or asking for their views on your plan?**
- **Don't talk down to them** – you cannot necessarily treat them as an equal as there are certain boundaries that need to be in place, however they are developing more autonomy which they need to explore.

Changing risk factors

Adolescents take more risks than younger and older age groups, so will potentially be at risk from many areas, of their own making (e.g. through their actions), through pressure from themselves and others (e.g. self harm / suicide) and from others around them, both in their physical world and also their online world.

For further information on working with adolescents

- See the NSPCC research – [What serious case reviews tell us about working with adolescents](#)
- A site for young people by young people looking at current issues – [riseabove.org.uk](#)
- Read [Adolescents and Risk: Helping Young People Make Better Choices](#)

To speak to someone about concerns about an adolescent...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Current thought is that adolescents are aware of their vulnerability, but when weighing up the pros and cons immediate reward (e.g. acceptance by friends) is far greater than the chance that something bad might happen (e.g. serious accident).

As professionals we need to be aware of the language that we use to describe adolescents – for example a common term that is used is that a young person is 'streetwise', with this often being used as a reassurance that things will be OK. If you turn that on its head, 'streetwise' could be described as the young person often getting into scrapes which they have been lucky enough to get out of so far. That does not mean that on the next occasion they will be so lucky.

Consent to information sharing

As children get older they have a greater understanding of the world around them and, with full information become able to make informed decisions. So long as they are considered to be able to make such decisions, young people should be asked whether they consent to information about them being shared and given the opportunity to make an informed choice. As with any situation there may be times when the young person's decision may have to be overridden, however the young person should be told when this happens and why.

Young Carers

"A young carer is someone aged 18 or under who helps look after a relative who has a condition, such as a disability, illness, mental health condition, or a drug or alcohol problem.

Most young carers look after one of their parents or care for a brother or sister. They do extra jobs in and around the home, such as cooking, cleaning, or helping someone to get dressed and move around.

Some children give a lot of physical help to a brother or sister who is disabled or ill. Along with doing things to help their brother or sister, they may also be giving emotional support to both their sibling and their parents."

NHS Choices, 2015

All young carers are entitled to an assessment, either at the point that any agency (children's or adult's) identify that they are a young carer or when a young carer or their family asks for an assessment. The needs of everyone in the family must be considered to reduce and remove the caring responsibility placed on the child if possible.

Impact on young carers

A report by the Children's Society in 2013 found:

- Young carers are one and half times more likely to have a special educational need or a long-standing illness or disability
- One in 12 young carers is caring for more than 15 hours per week
- Around one in 20 miss school because of their caring responsibilities
- Young carers have significantly lower educational attainment at GCSE level - the equivalent to nine grades lower overall than their peers

- Young carers are more than one-and-a-half times as likely to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer
- Young carers are more likely than the national average to be 'not in education, employment or training' (NEET) between the ages of 16 and 19

Essentially, through taking on caring responsibilities, young carers are missing out on their childhoods.

Identifying young carers

Young Carers are not a homogenous group, why they undertake a caring role will be different dependent on the parent's or sibling additional need. Caring often occurs over time and may grow to meet the emerging needs within the family.

The term does not apply to everyday and occasional help expected of or given by children – the key feature for a young carer is that what they do ensures the health, safety and / or day to day wellbeing of the person cared for and / or the wider family. Consider:

- what is being done.
- why the young person is doing it.

- how often these things are being done.
- the extent to which the young person has sole or unsupervised responsibility for any activity that might usually fall to an adult.

If you think a child may be a young carer contact MASH so that an assessment can be completed.

For further information on young carers

- For local information see the [Devon Young Carers](#) website
- Read the report [Hidden from View](#) by the Children's Society (2013) which looks at the impact on young carers
- Take a look at the [Carers Trust](#) website
- For useful information for young carers see the [Know Your Rights](#) leaflet by the Children's Society

To speak to someone about concerns about a child being a young carer ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Emotional and mental wellbeing

Good emotional wellbeing and mental health impacts on every aspect of our lives, providing the foundations for strong family relationships, high educational attainment, reducing anti-social behaviour and improving social inclusion.

Poor emotional wellbeing and mental health in children can be associated to a number of factors in a child's environment, their community, their home life as well as uniquely individual factors such as their genetic make-up.

The causes of poor mental health are complex. Factors that are known to have an impact are:

- Long-term illness
- Parental substance misuse / mental health issues / offending behaviour
- Loss of a person close to them
- Poverty
- Victim of bullying or abuse including through discrimination

The presence of these does however not mean difficulties are necessarily going to arise.

Warning signs

These can include:

- Changes in school performance
- Inability to cope with day to day problems
- Changes in sleeping and / or eating habits
- Lasting negative mood
- Frequent outbursts of anger
- Self harm

It's good to talk ...

The following advice is from the Samaritans:

- Often people want to talk but won't speak unless asked
- Don't be afraid to ask questions – make them open ended (e.g. 'Tell me about ...', 'How do you feel about ...')
- Focus on their feelings instead of trying to solve the problem
- Try to let them make their own decisions.

Suicide / suicide attempts

Suicide and talk of suicide can be very difficult to deal with. If you are working with a young person who is thinking about suicide (e.g. making threats, drawing up suicide plans, pre-occupation with death, making final arrangements) then it is important to seek help immediately.

For further information on emotional health

- Take a look at the [Young Minds website](#)
- Read the Children and Young People page on the [Mental Health Foundation website](#)
- Refer to SWCPP – [Suicide and suicide attempts](#)

To speak to someone about a young person who you have concerns about...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Young people, drugs and alcohol

The number of young people who use drugs and / or drink is relatively small, with the annual schools survey recording that under a fifth of all pupils reported that they had ever used drugs. This is a national picture and there are regional variations, even within Devon.

Certain groups are at increased risk of substance misuse:

- Looked after children
- Children excluded from school or regularly truanting
- Children involved with the youth justice system
- Children involved with safeguarding agencies
- Children with additional needs such as learning needs or developmental disorder (e.g. ADHD)
- Children living in families where there is already substance misuse

Assessment

Initial assessment of attitudes towards drugs and alcohol does not require specialist input. Through talking with young people you can establish what their knowledge of drugs / alcohol is and create the opportunity to talk about their individual use (if any use). This can be woven into the overall assessment process. If the conversation does reveal concerns then referrals can be made accordingly.

Safeguarding concerns

If a young person does disclose that they are using drugs and / or alcohol, then you need to consider whether this information triggers safeguarding concerns. Such considerations should include:

- Why is the young person using substances (e.g. are they being exploited)?
- What is the parents' understanding? Is parental substance misuse normalising the role of substances in family life?
- Does the young person see their substance misuse as an issue?

For further information on substance misuse and young people

- For information about different substances and their impact have a look at the [FRANK website](#)
- Have a look at the [Y-Smart website](#) – the Drug and Alcohol Service for under 18's

To speak to someone about concerns about a child's substance misuse contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Online safety and abuse

The internet provides both opportunities and threats to young people, such as bullying, grooming, exposure to pornographic materials, radicalisation & extremism and sexual exploitation. It is not only computers that are internet enabled, with games consoles, mobile phones and tablets all allowing the children who use them access to chat rooms, pornography and other sites where they may be at risk.

Sign of abuse

The NSPCC propose that if the child:

- spends lots, much more or much less time online, texting, gaming or using social media
- is withdrawn, upset or outraged after using the internet or texting
- is secretive about who they're talking to and what they're doing online or on their mobile phone
- has lots of new phone numbers, texts or email addresses on their mobile phone, laptop or tablet

then they may be experiencing online abuse.

Munro identified that cyberbullying can make children and young people feel more frightened and helpless than bullying because they feel like they can't escape. It can also have a similar impact as bullying causing school failure, depression, anxiety and other mental health problems.

Working with families

Discussions about online safety need to become part of our standard conversations with the families we work with. Some key questions to consider are:

- does the family have a computer – where is it (e.g. in the front room, or in the child's bedroom)?
- does the child have access to games consoles (e.g. X-Box, Playstation) and are these connected to the internet?
- does the child have a mobile phone?
- do the child's parents / carers know what their child looks at on the internet, who they talk to, who their friends are?

Starting the discussion can lead to increased awareness in a family as often parents are not aware of how connected their children are.

Computer software that filters the sites that children can see is widely available, as is antivirus software. Ideally computers should be in a family area where there is regular oversight, but recognise that many mobile devices and gaming stations support internet use.

For further information on online safety

- Visit the thinkuknow, www.saferinternet.org.uk and getsafeonline websites for more information
- See the [e-safety page](#) on the South West Child Protection Procedures website
- See the [NSPCC page on online abuse](#)
- See the resources section of the childnet.com website

To speak to someone about a young person who you have concerns about...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Missing children

"A child or young person under 16 runs away every five minutes in the UK. [...] It is estimated that every year 18,000 children and young people under 16 sleep rough or with someone they have just met"

Railway Children
Reaching Safe Places

Children are missing if their whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another. Children who go missing are at significant risk of harm and abuse by others. Immediate risks associated with going missing include:

- No means of support or legitimate income – leading to high risk activities
- Involvement in criminal activities
- Victim of abuse
- Victim of crime, for example through sexual assault and exploitation
- Alcohol/substance misuse
- Deterioration of physical and mental health
- Missing out on schooling and education
- Increased vulnerability

Longer term risks include developing drug/alcohol dependency, involvement in crime, homelessness (or sofa surfing), disengagement from education, sexual exploitation and poor physical and/or mental health.

Research highlights risk factors that can precede a missing incident:

- Arguments and conflicts
- Conflict within a placement

- Poor family relationships
- Physical and emotional abuse
- Boundaries and control
- Step parent issues

What can we do?

Remain alert to the potential for a child to go missing. Children may run away *from* a problem, such as abuse or neglect at home, or *to* somewhere they want to be. They may have been coerced to run away by someone else. Keep in mind these '*push*' and '*pull*' factors when assessing a situation.

Devon has regional MACSE Missing and Child Sexual Exploitation forums to facilitate the identification of cases before sufficient information is known to necessitate a MASH enquiry. Each agency has a representative who can take cases to a MACSE.

Children and young people who go missing from care are particularly vulnerable. Develop risk management plans at the time of the placement.

For further information missing children

- Read the [statutory guidance](#) produced by the government in 2014
- Take a look at the [Railway Children](#) and [Children's Society](#) websites for general information
- Read the Barnardos publication '[Running from hate to what you think is love](#)' which considers the links between running away and sexual exploitation with case studies

To speak to someone about a young person who you have concerns about...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Recognising and Responding to Sexual Abuse

1 in 20 children in the UK **have been sexually abused**

1 in 3 children who were sexually abused by an adult **did not tell anyone**

Source: Radford, L. et al. (2011) as cited on the [NSPCC website](https://www.nspcc.org.uk)

Sexual abuse can include sexual abuse by a family member and child sexual exploitation (see following pages).

A child is sexually abused when they are forced or persuaded to take part in sexual activities. This does not have to be contact, and it can happen online. Sometimes the child won't understand that what is happening to them is abuse. They may not even understand it is wrong.

Sexual Abuse at a Glance, NSPCC

It is important that as professionals we are able to identify and respond to concerns of sexual abuse. Although this page provides brief information it is important that you seek appropriate advice.

Who is at risk?

Any child can be at risk from sexual abuse, and as the statistics at the top of the page show, a disclosure may not always be forthcoming – this may be for a number of reasons. The lack of disclosure should not stop you considering the possibility of sexual abuse.

Who are the perpetrators?

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children (including siblings and peers).

Key considerations

Sexual abuse is an emotive subject, and as such there is potential that as professionals we will look to find alternative explanations for what we are seeing.

It is therefore important that we are prepared to think the unthinkable. Ask yourself:

- Why is the child behaving in this way?
- If you are seeing sexualised behaviour, what is normal sexually inquisitive behaviour for a child of this age?
- What is the adult's presentation?
- Disability does not act as a protective barrier to sexual abuse.

The [Brook Sexual Behaviours Traffic Light Tool](#) can help you to identify and respond appropriately to sexual behaviours, providing a standardised approach to understanding healthy and harmful behaviour. It can be found through undertaking a search on the internet if you are unable to use the link above.



Thematic Review – Child Sexual Abuse



Child sexual abuse was the subject of a serious case review in 2014. Since then there have been further cases that have caused concern and so a thematic review was commissioned to identify key themes and areas where further work is required.

Why aren't practitioners investigating the likelihood of child sexual abuse as a presenting factor?

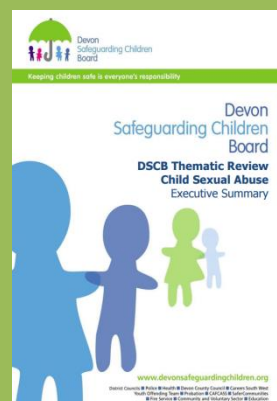
Identified barriers include:

- **Need for direct disclosure:** As agencies we are often disclosure led, and this reliance can prevent concerns being followed up. Research undertaken into child sexual abuse and accounts from survivors clearly documents that it often takes years for victims to disclose sexual abuse.

For more information see the executive summary. This can be found at:

<http://www.devonsafeguardingchildren.org/documents/2016/06/dscb-thematic-review-child-sexual-abuse.pdf>

- **Professionals not engaging with children:** The files examined often showed little reference to the experience of the children. Where direct work did take place this was inconsistent and focused on exploring other risks.
- **Inadequate information sharing:** A focus on event-based practice as opposed to looking at the bigger picture often means that important information is overlooked or not shared. Often information needs triangulating and this is only a process that can be completed over time.



- **Relevance of family history:** A common theme was that there were clear indicators in the family history that were overlooked or missed.

- **Adult centricity:** As seen

elsewhere, this review found that professionals remain too overly focussed on the needs of the parent and overlook the child.

- **Professionals doubting their ability to identify sexual abuse:** Practitioners may look for alternative explanations in order to avoid an emotive and difficult subject.

- **Grooming of professionals:** The review found that often professionals were manipulated by the offender or their family, and when coupled with professionals being overly optimistic, this meant that the true issues were overlooked.

Child Sexual Exploitation

Child sexual exploitation is where young people, both girls and boys, are groomed, forced, pressured or tricked into sexual activities or sexual images.

Sexual exploitation of children and young people under eighteen involves exploitative relationships, violence, coercion and intimidation being characterised in the main by the child or young person's limited availability of choice resulting from social and economic and/or emotional vulnerability. It is essential all agencies stringently do all they can to reduce incidents of missing young people and when a child does runaway robust efforts should be made to locate the individuals.

Sexual abuse can be very difficult to identify. Children who have been sexually abused may show a variety of signs and symptoms, including:

- becoming withdrawn, anxious or clingy
- depression
- aggressive behaviour
- sexualised behaviour inappropriate for age
- obsessive behaviours, eating disorders
- sleep problems, bed-wetting or soiling
- problems with school work or missing school
- risk taking behaviour during adolescence
- alcohol and substance misuse
- becoming sexually active at a young age
- promiscuity

For a few children these effects may be relatively short-term, depending on the individual child, the nature of the abuse and the help they receive. However, for many the effects can last into adulthood and cause a long list of problems, especially mental health problems and drug or alcohol misuse. Some children

are particularly vulnerable. Children in care are around 50x more likely to be targeted (25% of young people exploited).

Warning signs include a child who:

- suddenly starts to behave differently
- thinks badly/doesn't look after themselves
- displays sexually inappropriate behaviour, including use of sexual language and sexual information which you would not expect them to know
- has physical symptoms that suggest sexual abuse – these can include anal or vaginal soreness or an unusual discharge, and pregnancy
- avoids being alone with a particular family member
- fears an adult or is reluctant to socialise with them
- tries to tell you about abuse indirectly, through hints or clues
- describes behaviour by an adult that suggests they are being 'groomed' for future abuse
- is taken places by other people for sexual exploitation (trafficking)



Child Sexual
Exploitation training
at the **DSCB website**

For further information on sexual exploitation

- [SWCPP](#)
- [Peninsula Child Sexual Exploitation Strategy 2012-2015](#)
- [Child Sexual Exploitation threshold](#)
- [Missing/absent children – guidance](#)

To speak to someone about sexual exploitation contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Missing And Child Sexual Exploitation forums (MACSE)

Do you have concerns that a child or young person may be at risk of sexual exploitation? Do you have information about possible locations of concern or potential perpetrators of CSE and not sure what to do?

The **Missing And Child Sexual Exploitation forum (MACSE)** is a peninsula wide initiative and forums are held on a monthly basis across Devon in Exeter and East; North and South. The forums aim to proactively prevent children and young people who are not open to social care from being sexually exploited by:

- working together to gather local intelligence, identify potential risks and make plans for every child identified
- developing and implementing strategies for raising awareness of CSE and identification skills for key services in the localities e.g taxi drivers, hoteliers
- educating and skilling up the professional workforce in all agencies who have regular contact with children to identify and work with children and young people who are at risk of sexual exploitation
- scrutinising the locality data collected on missing children/young people to identify themes, trends and issues
- feedback any wider issues to the DSCB CSE sub group.

The forums have recently been remodelled to allow information sharing in relation to any sexual exploitation concerns.

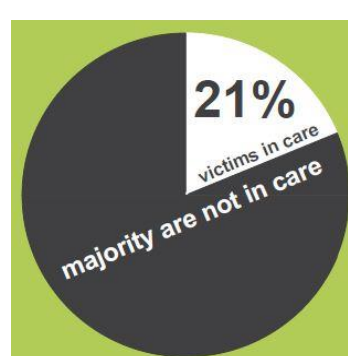
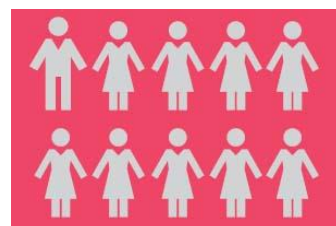
For more information see the [DSCB website](#) and search for MACSE.

Child Sexual Exploitation... in numbers

15

The average age of young people being exploited, although children can be at risk in primary school and many adults, particularly those with learning difficulties, are also at risk.

9 out of 10 young people accessing sexual exploitation services are female, although we know far more young men are also at risk. Do **you**

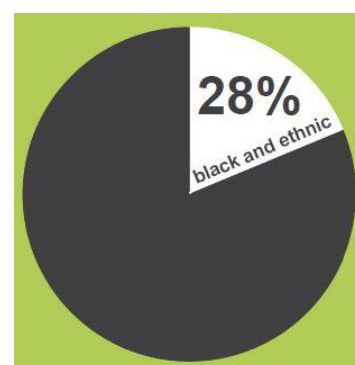


recognise the risk to young men?

Most young people are not in care, although children in care are many times

more at risk than their peers. Think about the risk to each.

Black children and children with disabilities are also more at risk. Identify their vulnerabilities, and take action to keep them safe.



Remember, young people can't consent to being exploited. Always assess the relationship.

Friends and gangs

Friendships are an important part of growing up. However we need to be aware that the concept of friends has changed with the evolution of online networks. Young people may say that they have hundreds of friends, but some online friends may be more acquaintances than friends.

When working with young people it is important to ask about friends and the value and importance that the young person places on the different friendship groups.

At this stage of development young people usually have a desire to belong to a group or network. Groups are different to gangs with the Office of the Children's Commissioner providing the following definitions:

Gangs are relatively durable, predominantly street-based, social groups of children, young people and, not infrequently, young adults who see themselves, and are seen by others, as affiliates of a discrete, named group who (1) engage in a range of criminal activity and violence; (2) identify or lay claim to territory; (3) have some form of identifying structural feature; and (4) are in conflict with similar groups.

Groups are two or more people of any age, connected through formal or informal associations or networks, including, but not exclusive to, friendship groups.

There are shared risks associated with

gangs and groups, such as young people involved in either can be caught up in sexual exploitation.

Safeguarding children & gangs

Young people may join gangs for a number of reasons (e.g. respect, status, belonging, protection, peer pressure). It's not just boys that can be affected by gangs, girls can too. Gangs will however have certain expectations of their members, both to remain in the gang and if the individual wants to progress through the hierarchy of the gang.

Government guidance identifies the following key children who may be particularly vulnerable to suffering harm in a gang context as those who are:

- not involved in gangs, but living in an area where gangs are active, which can have a negative impact on their ability to be safe, healthy, enjoy and achieve, make a positive contribution and achieve economic well-being;
- not involved in gangs, but at risk of becoming victims of gangs;
- not involved in gangs but at risk of becoming drawn in, for example, siblings or children of known gang members; or
- gang-involved and at risk of harm through their gang-related activities (e.g. drug supply, weapon use, sexual exploitation and risk of attack from own or rival gang members).

For further information on gangs and their impact

- See the [Office of the Children's Commissioner's report](#) about CSE in gangs and groups
- Read the government guidance – [Safeguarding children and young people affected by gang activity](#)
- Take a look at the government leaflet providing [advice to parents and carers on gangs](#).

To speak to someone about a child being over influenced by their peers ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Often the gang members are victims in their own right as well as offenders and therefore need safeguarding as well as work undertaking to address their offending behaviour. This therefore requires a multi-agency approach to planning interventions – it should also be remembered that once a young person is in a gang, it is not easy for them to leave and therefore interventions should plan for the longer term.

Children in care

Children can be in care by agreement with parents or by order of a court. Most children in care are safe from harm and do well, with strong plans to ensure that their needs are met. For some there are particular risks. Children in care have many different experiences prior to becoming looked after, and this increases their vulnerability (e.g. adverse parenting, abuse). There are also risk factors which are related to being in care:

- risk of offending behaviour
- risks associated with separation and loss
- risk of institutional abuse
- risks re: lack of suitable placements
- risk associated with instability in placement / lack of consistent carer
- previous experience of abuse increases risk of being abused in the future
- risks in transition to adulthood.

Research shows that many of these risks are reduced when there is stability in placement with good professional support from a range of agencies.

Leaving care

Young people live independently, return home or to family or friends. When returning home or leaving care the risks can be particularly high. Up to two thirds of all children returning home from care may face significant risk unless there is adequate:

- Assessment
- Planning & preparation
- Post return support and monitoring

Sometimes misplaced optimism by the professionals places children at risk. Check out the evidence to support or challenge your decision during the assessment phase and then look at it critically to check that it really does support your point of view.

For children moving to independence there are risks associated with isolation, poor preparation for independence, lack of people to demonstrate how things should be done (e.g. budgeting). Young people who have been through the care system often need extra support around managing their emotions and the daily stress of life.

Ensure you think about how young people in care can be supported in the same way that a child living with their birth family might be supported – supporting learning for independence is not something that can be done over a short space of time but something that should be integral to everything that we do.

For further information in relation to the risks for children in care

- Look at the NSPCC report – [Promoting the wellbeing of children in care: messages from research](#)
- Read the Barnardos report – [Someone to care: experiences of leaving care](#)
- Read the NSPCC report – [Returning home from care: what's best for the children](#)

Youth Offending

Young people may come to the attention of the Police and courts for a number of reasons. Those over the age of 10 can be held responsible for their actions in the eyes of the law.

Offending behaviour can have significant and life changing effects on a young person. Wherever possible the aim is to divert young people away from the court process, whilst getting them the help they need.

The Youth Offending Team (YOT) is a multi-agency team that aims to work with the young person to address offending behaviour whilst looking at the social issues that surround them. A YOT may become involved on a voluntary basis with the young person, or where a court has made an order (much the same as Probation does for adults).

Young people are more at risk of offending if they:

- have difficulties achieving at school or attending school
- are involved in bullying (this can be as victim or perpetrator)
- have behavioural issues / hyperactivity or poor impulse control (e.g. ADHD)
- have specific learning needs (e.g. dyslexia)
- live in an environment where there is conflict or abuse
- live in an environment where there is alcohol or substance misuse
- live in a community where crime is condoned

This reinforces the need to identify the needs of young people and work to address those needs.

PREVENT agenda

With increasing concerns about radicalisation of young people there is a need to actively challenge extremist views and prevent young people being drawn into terrorism.

All professionals have a responsibility to identify young people who may be at risk of radicalisation and refer through MASH.

CHANNEL process

You may be asked to be part of a Channel meeting. This is a multi-agency meeting that aims to identify whether an individual is at risk of being drawn into terrorism along with the nature and extent of that risk. The meeting will then develop a support plan for the individual which is reviewed regularly.

Channel aims to protect and divert young people from the risks they face through early multi-agency intervention.

More information about the Channel Process can be found on the [gov.uk](https://www.gov.uk) website.

For information on Youth Offending

- Read the [Devon Youth Offending Service website](#)
- See the government website – [Young people and the law](#)
- Refer to SWCPP – [Violent extremism](#)
- See the government website – [Protecting the UK against terrorism](#)
- See the Association of Chief Police Officers website - [Channel - Protecting Vulnerable People from Being Drawn into Terrorism](#)

Disability

There are many myths around disabled children that mean that our view about the need for safeguarding can become jaded, even though these children are more likely to be abused than their peers. The abuse of disabled children is often undetected and even when suspected is under reported. One reason that is cited for this is that as professionals we over-empathise with the parents and tolerate certain behaviours more than we would with parents of non-disabled children.

Open-minded

It is therefore important that we maintain an open mind about what we are seeing, and as suggested by Lord Laming, maintain a professional curiosity. For example:

- not accepting that an injury is a result of the needs of the child, but instead consider what other causes there may be and what the evidence suggests.
- considering a behaviour such as self-harm as possibly being indicative of abuse.

It is important that there are also clear lines of communication between all involved in the child's care so that concerns can be discussed and referred as necessary.

Myth	Fact
<i>Nobody would abuse or neglect a disabled child...</i>	Research shows they are more than 3 times more likely to be abused.

Myth	Fact
<i>Disabled children are well protected because of all the helpers they have...</i>	Because they rely on so many people to help them, often with personal care, they are at greater risk of someone abusing their trust.
<i>Disabled children are not attractive to abusers...</i>	Abusers are usually driven by desire to dominate and some disabled children can be seen as particularly helpless.
<i>You can't expect disabled children to be as well dressed and turned out as other children...</i>	When loved and cared for disabled children are as well turned out as any other child.
<i>Disabled children won't be believed... and will not be able to give evidence in court...</i>	Many abusers think this – but with the right help and support all disabled children can tell or show what happened to them.
<i>If the child cannot speak s/he cannot communicate...</i>	A wide range of communication systems and equipment is available and skilled people to help children communicate.
<i>You can't be expected to get the views of disabled children as you can't be sure that they are expressing their own views and opinions...</i>	Article 12 of the United Nations Convention on the Rights of the Child is very clear: Every child has a right to express their views regarding all matters that affect them; and for those views to be taken seriously.
<i>Abuse doesn't have the same effect on disabled children...</i>	The betrayal of trust and hurt is as acutely felt as by any other child.

Reproduced from: Scottish Government Ministerial Working Group (2014) Child Protection and Disability toolkit

For further information on safeguarding disabled children

- Refer to SWCPP for more information on [safeguarding disabled children](#)
- Look at the government guidance – [Safeguarding disabled children: practice guidance](#)
- See this [article from Community Care](#) about how research should inform our work with safeguarding disabled children

To speak to someone about concerns about a disabled child ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Multi-agency case audit

In the first half of 2015 the DSCB considered the issue of children and young people with learning difficulties and disabilities. The DSCB met with professionals from health, education and children and family services to discuss the issue, with the aim of producing an action plan to improve safeguarding measures and procedures.

What was going well?

- Positive examples of multi-agency working (including special schools, occupational therapists, social care and Integrated Children's Service)
- Excellent examples of work by special schools in Devon
- Good examples of advocacy (although this was ad hoc)
- Examples of good practice including early diagnosis and appropriate social worker allocation

What was not going so well?

- The child protection arrangements and procedures often leave people feeling confused. The experience appears process lead rather than child lead
- Lack of placement options
- Lack of consistency of staff
- Different agency systems and protocols create barriers for communication and multi-agency working
- Access to safeguarding supervision is inconsistent
- Transition from children's to adult's services is not timely
- School transport changes and inconsistency causes problems
- The voice of the child is not being heard at all times
- Not all special schools have a named nurse
- Disguised compliance or lack of commitment by parents

- In four of the cases, the child's disability was used as a smoke screen for neglect and emotional abuse
- Access to services in rural areas is poor
- Think Fathers – the current process is overwhelmingly focused on the mother

What does this mean for me?

- Think about how you can work to address the issues identified in the audit
- Think about the top five barriers to protection for disabled children:
 1. Lack of professional expertise
 2. Assessment against thresholds impaired through over empathy with parents / failure to recognise risk / number of professionals involved
 3. Disabled children less likely to disclose
 4. Issues around communication
 5. Issues around education
- If you have concerns use the threshold matrix to look at what information you have and establish where this falls in terms of level of need
- Ask yourself – what would I do if I saw this happening with a child who does not have additional needs? Would I be concerned?

[Guidance](#) has been issued around talking to young people with life limiting or life threatening conditions about sex, sexuality and relationships. Developed by the Open University with together for short lives, this document sets out standards for staff and organisations as well as providing information as to how best to support young people and their families around sexuality, relationships and intimacy.



Fabricated or Induced Illness (FII)

Fabricated or induced illness involves carers:

- presenting a well child as ill or disabled
- presenting an ill or disabled child as having more significant problems than they have really.

These presentations can cause significant harm for the child either because of being made to be ill, or through the treatment that they are given for an illness that they do not have. The harm is not only physical but emotional.

There is little information about the prevalence of such cases, but it is believed that these are unreported as there is not necessarily a clear cut pattern of incidents. For professionals involved in treating the presenting symptoms it is not always easy to step back and consider the overall picture.

Where children are consistently being presented as ill it is important that:

- there is clear and direct communication between the professionals involved (i.e. not relying on the parent to report back on appointments, etc.)
- a chronology of presentations is maintained
- case records explicitly state who the source of the information being recorded was and when the information was provided
- a paediatrician or other suitably qualified medical practitioner (e.g. named nurse) is asked to review the case records from an

independent viewpoint and provide an opinion.

If you have concerns that a child is victim of fabricated or induced illness then a referral should be made to MASH.

This is one occasion when you would not seek the consent of the parents, as research tells us this can heighten the risk for the child.

For further information on FII

- See the [Fabricated or induced illness page](#) on SWCPP for more information
- Have a look at the NHS Choices page on [fabricated or induced illness](#)
- Read the government guidance – [Safeguarding children in whom illness is fabricated or induced](#)

To speak to someone about concerns about illness in a child being induced or fabricated ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Listening to children

“...probably the single most consistent failure in safeguarding work with children... [is]...the failure of all professionals to see the situation from the child’s perspective and experience; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views in supporting their needs”

OFSTED
Evaluation of Serious Case Reviews

Children can’t always put feelings into words, so listening includes seeing their behaviour as communication. Listening is about two-way communication between you and the child, with each person valuing and respecting the views of the other. Every child has a right to express their views and have them taken seriously (Article 12 of the UN Convention on the Rights of the Child).

Non-verbal communication is significant in all communication and for many is the most important aspect. Children who are unable or unwilling to verbalise (e.g. due to young age, physical impairment or active decision) communicate through body language and actions about how they feel and think. For example, a young baby can’t say who she sees as her parent figure, but her reactions to her parents show us how she feels.

Active listening

NSPCC research with children who disclosed abuse showed that fear of not being listened to, understood, taken seriously or being believed was a

barrier to sharing worries with adults. They worry adults trivialise or over react and make matters worse.

To build trust:

- **Be there** – the child feels you are there for them
- **Prove yourself**– take the time to listen, respond appropriately and keep promises
- **Have the right attitude** – don’t be too shocked, lose your temper or take over
- **Know what you are talking about** – know what to do, share relevant experience. Sometimes it is ok to say you don’t know, but that you will find out

Language & communication

Some children have obvious or hidden speech, language and communication needs. With hidden difficulties the child may:

- struggle to understand words or sentences
- have difficulties in knowing how to talk and listen to others in a conversation

These children can struggle on a daily basis, become withdrawn and isolated, or have problems controlling emotions or feelings.

Consider using interpreters and check young people understand and respond accordingly.

Competence

People you work with should understand concerns you raise and decisions you make with them.

Young people can make decisions if they are ‘Gillick competent’, ie, “[when the child achieves sufficient understanding and intelligence to understand fully what is proposed](#)”. This can be about any decision, not just decisions about medical care.

There has been confusion about Gillick competence and Fraser guidelines. Gillick competence relates to when young people are able to make decisions. You should consider their ability and the complexity of the decision. Fraser guidelines relate specifically to a young person's ability to understand and consent to contraceptive advice and treatment.

The Mental Capacity Act

The Mental Capacity Act applies to anyone over the age of 16, including some young people and parents, who are unable to make a decision because their mind or brain is affected by, for example, illness or disability. You should consider whether they can understand the information being given, retain it long enough to make a decision, weigh up the options and communicate their decision. If you are unsure, seek advice and undertake a Mental Capacity Assessment.

Further information around mental capacity can be found [here](https://amcat.org.uk) (amcat.org.uk)



You can learn more about the Mental Capacity Act on our [**learning course**](#)

Advocacy

Safeguarding processes can be scary and overwhelming, particularly for children at child protection conferences.

Advocates provide independent support to children in these situations.

Advocates will work with the child to make sure that they understand what they are being asked to do, as well as helping the child to work out what they want to say.

It's not just for children ...

Advocacy is not just restricted to being a support to children. Advocates are also an important form of support to families as a whole – for example when working with families with specific cultural backgrounds (e.g. travelling families). Advocates who have good links with the specific communities can often help to reduce the potential barriers between the community and the need for professional involvement (which the community and therefore the family may be resistant to).

For further information on listening to children

- Take a look at [Community Care](#) for some tools that all practitioners can use to talk to children
- Read about speech, language and communication needs on the [Communication Trust](#) website or the [ican](#) website
- See the [Devon Advocacy Consortium](#) website for advocates for adults.

To speak to someone about a young person who you have concerns about...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Working with men

A common theme in serious case reviews is that in many assessments the men that are in the household are missed, either through not wanting to engage or not being there when the professionals visit. Often these men are either partners of the mother, or frequent visitors to the home.

It is important that when working with families a clear picture is built up of who is in the home. This is not only biological family but includes questions such as:

- who else lives in the home (i.e. are there any extended family, current partners, lodgers also living in the home)?
- what relationship (if any) do they have with the child?
- how much care do they provide for the child?

It is important the role of fathers is also recognised. All too often we work with the mother as the main care-giver, but do not often see the father. Research shows that the active involvement of the father in the life of the family can result in lower levels of neglect, even in the face of other serious issues such as poverty and unemployment.

It is also key that we involve fathers in every aspect of the service that we provide – the Fatherhood Institute suggests that sending dads off to separate services for fathers further enhances their exclusion from the ‘process’ and results in poor engagement. This may mean that, for example, we have to look at when we visit so that the father can be present and involved.

Finally, it is not all about what level of risk the man poses:

[We] tend to see men in a family as either a risk or a resource, but this is ineffective, says Mark Osborn, safeguarding programme manager with the Fatherhood Institute. "Even a father who displays risk factors, such as violence, may display some protective factors. The challenge is to identify interventions that bring forward those protective factors while keeping the risk under control." (Community Care, 2013)

For further information on working with men

- Have a look at the Community Care article on [Engaging fathers](#)
- Take a look at the [Fatherhood Institute](#) website for more information.

To speak to someone about concerns about a child ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Through their analysis of serious case reviews the NSPCC have identified four risk factors relating to hidden men:

- 1) Lack of information sharing between adult's and children's services.** This refers to services who work with adults not being aware that they have contact with children and therefore not knowing to share information about potential risk.
- 2) Relying too much on mothers for essential information.** Often we rely on the mothers to

tell us about the men involved in the children's lives – if the mothers are prioritising their own needs they may not be honest about the risk these men pose to their children. Only through talking to a wider network of people involved with the child can inconsistencies be spotted.

3) Not wishing to appear judgmental about parents' personal relationships. We can be reluctant to judge parents decisions about personal and sexual relationships, however this may mean risks are overlooked.

4) Overlooking the ability of fathers to provide safe care for their children. Fathers can be very important to a child's development and they may be able to provide protection and stability where a child's mother cannot.

See [Hidden men: learning from case reviews](#) on the NSPCC website for more information.

Culture and religion

Every assessment should "reflect the unique characteristics of the child within their family and community context" (Working Together 2015). Religion or cultural requirements do not excuse child abuse. As professionals we need to be **culturally competent**: aware of our practice enough not to alienate the child and their family, but not distracted by faith and cultural practices meaning we lose sight of any potential harm.

Culturally competent practice

In order to be culturally competent we should be responsive to and respectful of the beliefs, practices and cultural and linguistic needs of diverse communities. We should:

- Value diversity – e.g. differences between and within cultures
- Have a capacity for cultural assessment – be aware of how our actions affect people from other cultures (e.g. how does it affect the dynamics if you are seen as an authority figure?)
- Be conscious of the inherent dynamics when cultures interact – for example, if a minority group has historically been oppressed this can be the cause of mistrust of members of the majority culture (e.g. Roma gypsies)
- Institutionalise cultural knowledge – ensure that it is not just individuals who are culturally aware but this is embedded in agency practice
- Adapt to diversity – consider how we can change our practice to fit cultural norms and adopt traditional values without compromising the need to protect children.

Safeguarding children

The presence of culture or faith should not alter the work that we undertake to safeguard children. Everyone has a culture and a stance in relation to their faith. Culture and faith are not something that has been introduced through immigration, so we should also be aware of the impact of the British culture and different faiths on the children and families we work with.

The overriding question is "what does this mean for this child?" and ensuring we maintain professional curiosity throughout our involvement with the child and their family.

Forced Marriage

In some cultures there is a tradition that marriages are arranged, for example by a matchmaker or some other person of standing within the community.

In an arranged marriage both parties consent to the assistance or their parents or a third party in identifying a spouse, but the individuals concerned are given a free choice over whether they want to accept the arrangement.

In a forced marriage either one or both of the individuals have not been given the opportunity to give their consent and usually there is some form of coercion or duress involved. For example, parents may state that if the individual does not go through with the ceremony they will bring shame to the family. In some cases the individual is taken abroad without being told the reason until the day of their wedding.

In the United Kingdom forced marriages are illegal, as is the removal of a person from the country for the purposes of a forced marriage in a different country. Forced marriage can be seen as a form of domestic abuse.

Honour based violence

“A collection of practices, ... used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour”. Violence can occur when the perpetrator believes a relative has shamed the family and/or community by breaking an honour code.

The Metropolitan Police give the following examples as to when honour based violence may be committed:

- When a person becomes involved with a boyfriend or girlfriend from a different culture or religion
- When a person wants to get out of an arranged marriage
- When a person wants to get out of a forced marriage
- When a person wears clothes or takes part in activities that might not be considered traditional within a particular culture

Boys and men can be victims of honour based violence in the same way as girls and women. Honour based violence is not just when someone is killed, and may include:

- domestic abuse
- threats of violence
- sexual or psychological abuse
- forced marriage
- being held against your will or taken somewhere you don't want to go
- assault.

For further information on working with culture and religion

- See the [racism](#) page on SWCPP for more information
- Have a look at [practice guidance](#) developed by the London Safeguarding Children Board
- Read the government guidance – [National action plan to tackle child abuse linked to faith or belief](#)
- Read the government's practice guidelines on [handling cases of forced marriage](#).

To speak to someone about safeguarding concerns ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Female genital mutilation



Female genital mutilation (sometimes wrongly referred to as female circumcision) refers to procedures that intentionally alter and cause injury to the female genital organs for non-medical reasons. It is illegal in the UK.

It is estimated over 20,000 young women under 15 are at risk of female genital mutilation (FGM) in the UK each year, and 170,000 women in the UK are living with the consequences of FGM (NHS, 2014). The true extent is unknown due to the 'hidden' nature of the crime.

New reporting requirements identified 5,702 new cases in England in one year.

Young women may be taken to another country to be mutilated during the summer holidays. Some young women may be abused in the UK.

FGM is usually carried out on young girls between infancy and age 15, most commonly before puberty starts. The procedure is traditionally carried out by a woman with no medical training. Anaesthetics and antiseptic treatments are not generally used and girls may have to be forcibly restrained.

Countries that have significantly high numbers of cases include Somalia, Eritrea, the Sudan and the Gambia.

FGM can cause severe pain, bleeding, wound infections, inability to urinate, injury to vulval tissues, damage to other organs and sometimes even death. Other complications can arise later with the onset of puberty.



Try the Home Office
elearning course

Your responsibilities

If you believe there is a risk of FGM you must notify MASH immediately, without seeking consent from the family. The Serious Crime Act 2015 introduced a duty on all professionals to notify the chief of police, orally or in writing, within a month of discovering that FGM appears to have been committed on a girl under 18. This notification will not breach any confidence of the child.

FGM is abuse. Courts may make FGM Protection Orders which aim to protect specific children from being harmed.

For further information on FGM

- See the [South West Child Protection Procedures](#)
- Read the [Multi-Agency statutory guidance on Female Genital Mutilation](#) (HMG 2016)
- Have a look at the Female Genital Mutilation web app – [Petals](#)
- Watch a [film about FGM](#)
- Watch the Channel 4 documentary – [The Cruel Cut](#)

To speak to someone about FGM ...

Contact MASH on 0845 155 1013 or email mashsecure@devon.gcsx.gov.uk

Domestic violence and abuse

Many children in Britain live with domestic abuse and are physically and emotionally hurt as a result. They see parents or carers suffer, often at the hands of someone else they love. They suffer physical, sexual and emotional abuse themselves. Sometimes they are forced into colluding with the violent partner; sometimes they feel deeply responsible for the non-abusing parent or carer, or for their brothers and sisters. Children can be further affected when adult victims of domestic abuse sometimes find it difficult to be the caring, supportive parents they would want to be, even after leaving the abusive relationship, because they have been hurt and traumatised by their experiences.

Domestic and sexual violence or abuse can be frequent and persistent with the highest repeat victimisation of any crime. 7% of women and 4% of men were victims of domestic violence or abuse in the last 12 months with 30% of women and 17% of men a victim at some stage since the age of 16. There were children present at 39% of domestic violence incidents attended by Devon & Cornwall Police in 2010-11. The Home Office estimate 750,000 children witness domestic abuse every year across the country.

National figures indicate that nearly three quarters of children with a child protection plan live in households where domestic abuse occurs. In Devon 65% of children on a child protection plan were living in a household with past or on-going domestic violence (22% of CAFs).



From the 20th July 2016 Devon will have a sub category of domestic violence on child protection plans to help parents understand where concerns are linked to domestic abuse.

The impact of violence and abuse can be devastating. Many victims suffer physical harm, which is fatal in extreme cases. Death may result from the violence itself or through suicide because the abuse and subsequent mental illness has made their life difficult to bear. Other victims may lose their home, be unable to hold down a job or a relationship, and become isolated from friends and family. Children may also be at risk, either by witnessing violence or by being victims of abuse themselves.

In relationships where there is domestic violence, children witness about three-quarters of the abusive incidents. About half the children in such families have themselves been badly hit or beaten. Sexual abuse and emotional abuse are also more likely to happen in these families.

Identification

Children and young people will be distressed by living with domestic violence and may show a range of mental and physical symptoms. In younger children they may show developmental regression including bed wetting or temper tantrums. They may also become anxious and complain of stomach-aches. Older children react differently with boys much more outwardly distressed such as being more aggressive and disobedient, increasing likelihood of risk taking behaviours in adolescence including school truancy and start to use alcohol or drugs. Girls are more likely to internalise issues by withdrawing from social contact and become anxious or depressed. They are more likely to have

an eating disorder, or to self harm. Children of all ages with these problems often do badly at school. They may also get symptoms of posttraumatic stress disorder, for example have nightmares and flashbacks, and be easily startled.

In the longer term children who have witnessed violence are more likely to be either abusers or victims themselves echoing the behaviour which was normalised within their household. The repetition of violence is not a forgone conclusion but even for those who break the cycle, children from violent families often grow up feeling anxious and depressed, and find it difficult to get on with other people.

Priorities in assessment

- Protecting the child is the first priority – what is it like to live in that house?
- Protecting the non-abusing parent – however it must not be assumed that that parent is not an abuser in their own right.
- Look at the pattern, not solely at individual incidents.
- Holding the perpetrator responsible for the abusive behaviour.
- Respecting non-abusing parents' right to manage their own life without placing their child at increased risk of further harm from domestic abuse.
- Guard against over-identification and maintain professionalism.
- Do not make assumptions about other agencies knowledge and processes.

Domestic Abuse & Safeguarding

Domestic abuse is a child protection issue. The impact of domestic violence and abuse on an individual child will vary according to the severity of the

abuse, the child's resilience and the strengths and weaknesses of their particular circumstances. The Children Act 1989 now includes 'impairment suffered from seeing or hearing the ill treatment of another'.

What reduces risk to children?

A strengths based approach which recognises their resilience & understands strategies children and carers already have for living with adversity.

Recognise domestic abuse as a multi-agency issue involving services for children, women and men across the voluntary and statutory sectors – Devon have a [Risk Identification Checklist](#) that mean we can work to a common view of what constitutes domestic abuse and the level of risk.

A whole "child and family" approach that is as enabling and empowering as possible.

Good links with relevant adults' services (in particular mental health or substance and alcohol services) so that these services

Focus on the child's needs and provide effective support for good enough parenting.

Services and individual interventions which focus on building resilience for the child or young person, including taking into account the significance of informal support networks.

Services that are able to provide consistent support for as long as is needed. For more information visit: <https://new.devon.gov.uk/dsva/information-for-professionals/>

behaviour

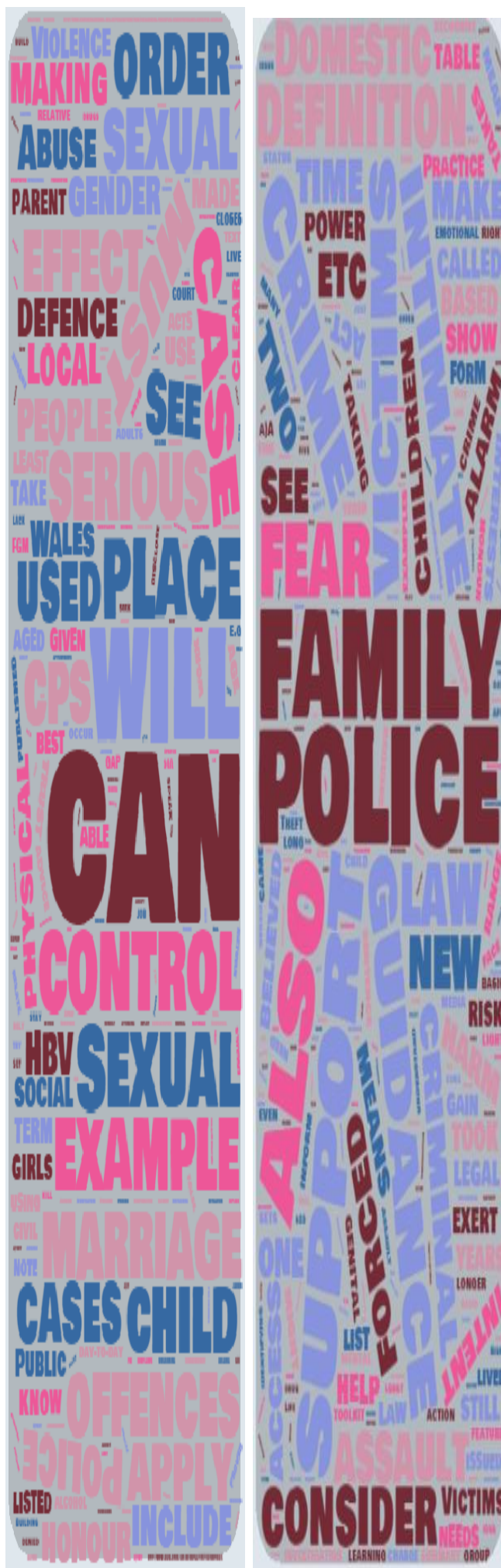
The victim and perpetrator must be “personally connected” when the behaviour takes place, and the behaviour must take place repeatedly or continuously.

The behaviour must have had a serious effect on the victim (i.e. the victim has had cause to fear violence being used on them on at least two occasions) or had a substantial adverse effect on the victim's day to day activities (i.e. they have to significantly alter their activities on a day to day basis).

In summary, controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another.

**For further information on
controlling or coercive behaviour**

- See the [statutory guidance issued by the Home Office](#) (2015)



Parental mental ill health

Poor parental mental health can have a detrimental effect on the health and development of children, leading to an increased risk of mental health problems for the children themselves. Around one person in six adults in England had at least one common psychiatric disorder with women more likely to experience common psychiatric problems than men. Only around a quarter of those with a common mental health condition were receiving treatment for their condition.

It is thought about 30% of adults with a mental disorder have dependent children, 7% of which live in lone-parent households. Professionals who work with a specific client group should consider the needs of all family members, particularly the children. Early identification and assessment are key – in Devon 32% of CAFs sampled noted adult mental health needs.

What do we need to do?

The key question is how the parent's condition affects the young person? Talk to and listen to the parent, get alongside the child and find ways to hear their perspective on life. Are there others in the family who know what life is like? Which professionals have a good insight? Think about the child, the care they receive, the relationship with their carer, and the environment in which they live – the cornerstones of good assessment.

In complex cases specialist adult services bring another perspective on how parental problems impact on family functioning and parenting capacity. Strong professional links, joint protocols

and procedures between children's and adults' services help collaborative assessments and service provision.

The research indicates long term support is crucial: can the family or services fill the gaps?

Interacting factors

Parental mental health issues often occur in conjunction with other issues – childhood trauma or abuse, substance misuse, financial stress or poverty or domestic abuse may also be impacting on the parent and on the child. Where factors interact risk to children rises. Risk increases when children are involved in parental behaviours, become targets for aggression or rejection, or are neglected.

Children's responses

Many children show no long-term behavioural or emotional disorders from parental mental illness, especially when problems are mild, of short duration, without family discord & disorganisation and don't result in family breakdown.

Children's ability to cope is related to their age, gender and individual personality; a sense of self-esteem and self-confidence; of feeling in control and able to deal with change and having a range of approaches for solving problems. Secure, stable and affectionate relationships and experiences of success and achievement are all important protective factors. Children may also be protected by the other parent or family members, such as grandparents.

Closely monitor children's progress; improvements in parents' disorders don't lead to improved parenting.

“Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns. Published case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance.”

NSPCC - Disguised compliance: learning from case reviews (2016)

As professionals we are encouraged to look for signs of strength and positive changes, however we must never lose sight of our professional curiosity.

What might disguised compliance look like?

- Focusing on one particular issue – parents make sure one thing goes well to deflect attention away from other areas (e.g. with Daniel Pelka, school attendance improved whilst the abuse continued).
- Being critical of professionals – parents will seek to blame other professionals for things not happening, again deflecting attention away from things they have not done and seeking to split the professional group working with the family.
- Failure to engage with services – parents will promise to take up services offered but then not attend appointments due to other problems.
- Avoiding contact with professionals – parents will agree to certain targets and then avoid further contact with professionals.

Pre-arranged home visits also provide the opportunity for parents to tidy the home and remove evidence – e.g. making it appear that no-one else lives in the home.

What can we do as practitioners?

- Use chronologies – these help to show patterns of non-attendance, missed appointments, etc.
- Challenge parents – e.g. “you’ve told me about what you have done about this, but what about ...”
- Ask yourself – what is it like to be the child in family? What is the child’s perspective / lived experience?
- Remain outcome focussed – has change occurred and has this happened within the agreed timescale? This means that appearances of participation do not distract from what you are trying to achieve.

Role of managers / supervisors:

- Challenge practitioner’s perceptions – what evidence is there that change has occurred?
- Consider timescales – is change happening in the agreed time?
- Establish what life is like for the child in the home environment.

Poverty

Poverty cuts across all types of families and households from single mothers or large multi generation households through to elderly people living alone. This section currently focuses on the impact of poverty on families with children. From birth the life expectancy of Devon people living in poverty is lower when born into poverty – there is a difference of approximately 14 years between the lowest life expectancy at birth in the Ilfracombe Central Ward area (74.7 years) and the highest life expectancy in West Devon Chagford Ward (88.4).

The impact of poverty

Poor children's life chances are dependent upon a complex combination of low household income, a lack of equal opportunities and social exclusion. While some children who grow up in low-income households will go on to achieve their full potential, many others will not. Poverty places strains on family life and excludes children from the everyday activities of their peers. Many children experiencing poverty have limited opportunities to play safely and often live in overcrowded and inadequate housing, eat less nutritious food, suffer more accidents and ill health and have more problems with school work leading to low educational attainment as these children become adults they are more likely to be in poorly paid employment or economically inactive continuing the poverty cycle.

Tackling child poverty will help to improve children's lives today, and it will also enhance their life chances: enabling them to make the most of

their talents, achieve their full potential in life and pass on the benefits to their own children.

In Devon the rural nature of the County creates an isolation that can magnify the impact of poverty beyond its immediate effect. In addition, a relative low wage economy exists, and that will mean that even for families that are in work they may remain within the poverty thresholds.

What can you do?

The evidence is mixed about what can make a difference to these children's lives. However, key initiatives include:

- Promoting breastfeeding for babies
- Literacy, numeracy & basic skills promotion for parents and children
- Making it easier to access services – free school meals, smoke free homes, speech & language
- Making sure families have the money they need – a financial assessment in the DAF together with targeted advice, such as through [Quids for Kids](#) programme - a specialist benefits advice service for families of children or young people with additional needs.



A PARENT'S VIEW

Alice is a 4 year old girl who doesn't go to school or playgroup and doesn't get out much. Their dog toilets in the yard and Alice spends most of her time watching TV. She really likes the nature programmes. Her mum does love her, though...

This is not a real scenario, but it is based in reality. We are going to explore Alice's life and think about why things aren't so great for her. Begin by thinking about Alice. What is going wrong for her? What risks can you identify? What would be a good plan? Ensure she attends school? Get rid of the dog? As we tell you more about Alice think about your plan as we go...

Kimberley

Alice lives with her mum, Kimberley. Kimberley is 20. She is quite bright - was supposed to be going to university. But in Y11 she fell in with the wrong crowd, needed to challenge things, got into drugs and got an older boyfriend. Older? Well he was 19, and he wasn't really her boyfriend, just sometimes. He had lots of girls. He wasn't good to Kimberley, stopping her seeing her friends and was violent when he was drunk. Kimberley didn't like it. He hit her when she became pregnant.



That was when she ran.

Kimberley couldn't go home. It wasn't safe at home. She wasn't cared for at home. But she had her baby, she didn't want to lose her baby. Alice was the only thing that meant anything to her, that cared about her. She moved away. She was scared.

It wasn't an easy time. Kimberley kept Alice close, kept her safe. As she grew she told her, "It's not safe outside. You mustn't go outside, Alice. There are bad people."

But Alice was lonely, and Kimberley could see this. She wanted her daughter to be happy, wanted the best for her. So she got the dog... "You've got a friend now, Alice"



It's complicated. It always is.

Analysing the case study

To understand the problems for Alice we need to understand the problems for Kimberley. A good place to begin is thinking about what Alice means to Kimberley. She was the product of a violent relationship – there were many ways Kimberley could have internalised this – so far the information suggests Kimberley has really invested in Alice and may have left a violent partner to protect her, a good sign. But there are potential issues about what Kimberley needs from Alice – is this just a mother/daughter relationship, or was Kimberley looking to replace the care that she didn't get? It's not clear, we'll want to think about this area more.

The dog is important to Kimberley and probably to Alice. We need to ensure Alice isn't playing in faeces, but getting rid of the dog would set the couple up against us. We'll need to look at what they know about dogs and how we can ensure Kimberley is caring properly for the dog and caring properly for Alice.

We are affected by our past

Who we are is in large part formed by experience – what changes is how we learn from it. It sounds as though Kimberley's life has not been so smooth. We will want to hear from her what she experienced in parenting and at school. Over time if she trusts us she may talk to us about the impact of the abuse and substance misuse and other parts of her life we don't know about yet. We will want to think with Kimberley about how this impacts on Alice.

You are right to be concerned

Try to write down your worries. Having an understanding of your concerns helps you to:

- ✓ Think about why there's a problem
- ✓ Check that you do have grounds for concern
- ✓ Get support
- ✓ Be able to explain your concerns clearly to parents (sometimes they don't know what is wrong)

There is reason to be concerned about Amy:

- ✓ She needs more stimulation
- ✓ Is she protected from the faeces?
- ✓ How are other issues in her life
- ✓ How does Kimberley cope?
- ✓ Is Kimberley using drugs?

A good starting point would be to talk to Kimberley about your worries. The right person, thinking reflectively with the family in the right way, could make a significant difference to Alice and Kimberley by building their confidence and capacity and ensuring they access support.

Parental substance misuse

Children are at greater risk of harm when they are living in households with parental substance misuse problems, with a greatly increased risk of domestic violence and abuse, a poor home environment and exposure to unsafe substances. Associated issues include social isolation, emotional neglect and abuse, behavioural problems, inconsistent and disturbed care and routines, poor school attendances, difficulties with adult relationships and a much greater risk of adult substance misuse. Problems are often interlinked with other issues, for example, a study found 44% of those attending mental health services report alcohol or drug problems.

The risks

The effects of alcohol and drugs vary in each individual situation; excessive drinking and drug misuse can produce symptoms such as erratic mood swings, paranoia and hallucinations, or feelings of elation and calm, diminished concentration, memory impairment and a loss of consciousness. Withdrawal symptoms can induce nausea and vomiting, cramps, hallucinations and epileptic-type fits. Stable, but controlled, use of drugs or alcohol can minimise the above effects and this could be a reasonable medium-term goal of treatment.

Young children whose parents inject drugs are at risk of HIV/AIDS and hepatitis A, B and/or C from poorly stored used needles and syringes. Children may also be exposed to unsafe adults when their homes are used by other drug users and dealers.

What to do

Again early identification is important. About 1 in 10 children in the UK live with a parent with a substance misuse problem. Keeping aware in every family about the levels of consumption of both legal and illegal substances and talking with adults and children about how this impacts on the children in the family is crucial. 14% of CAFs sampled in Devon noted parental substance misuse as an issue – this is probably an under-representation. Gaining the family's trust and having a joint approach is important – there is specific training available in Devon on this area.

For further information on substance misuse, domestic abuse, parental mental health issues and parenting capacity see <https://www.education.gov.uk/publications/eOrderingDownload/Childrens%20Needs%20Parenting%20Capacity.pdf>



Access drug and alcohol services at Rise Recovery Devon:

Barnstaple	01271 859044
Newton Abbott	01626 351144
Exeter	01392 492360
Tiverton	07872 147796



Attend the Parental Substance Misuse training at the **DSCB website**

Parental learning difficulty

Parents with learning difficulties may justifiably believe that the odds are stacked against them when it comes to successfully raising their children without the involvement of a range of professionals from health and social care agencies. More adults with learning difficulties are becoming parents and approximately half of them will have their children removed, usually as a result of concerns about their care and upbringing. For professionals the challenges can feel equally daunting; how can they advise and support the parents whilst at the same time fulfilling their responsibilities to safeguard the day to day care, safety and development of the children?

Barriers to support

Many parents with learning difficulties feel doubly discriminated against and that all their lives are seen as a failure; services do not understand them, don't listen to them and don't expect them to succeed. Often there is no professional agreement about what is good enough parenting, different professionals both praise & criticise the same behaviour so parents have no confidence in themselves or in others' standards.

When to refer

Often parents are only referred to specialist services much too late - at crisis point when court action is considered and may not have previously received learning difficulty services. Often they have not had much contact with professionals in universal services and many workers have little understanding of how much support is required. A general lack of coordination and consistency between services compounds the difficulties.

Often professionals do not fully understand the impact on parents of having a learning disability and can hold negative, stereotypical attitudes, with fixed ideas about what should happen. Many have extremely high expectations and often want a concrete outcome which removes all risk. They also have differing ideas about parenting, often intervening without giving the parent the space to work their way through challenges or providing support when circumstances do become difficult.

What to do...

Mainstream services need to be better prepared and more aware of ways to identify and support people with learning difficulties. Workers need to act as interpreters, advocates, mediators and gateways to support. Proactive working across a wide range of professionals, including solicitors and health workers, holding information days, providing multi agency training and developing protocols need to take place. Successful examples include nurses who have made links with local health visitors and midwives and visits to children and families teams to talk to social workers. Practice tools have been developed to help staff identify a vulnerable parent and then to identify sources of support. By doing this, the needs of parents with learning difficulties are made more visible to other professionals, leading to more awareness and a better understanding.

For more information:

http://www.reconstruct.co.uk/docs/dl/110_parents_with_learning_disabilities.pdf

Safety at work / LADO's and Whistleblowing

In all our work with children and their families, we must consider the risk to ourselves, both physically and emotionally. In order to be an effective practitioner you need to feel safe, secure and supported by your organisation.

The role of the Local Safeguarding Children Board

A key function of any LSCB is to develop policies and procedures in relation to:

- training people working with children or in services affecting children's safety & welfare
- recruitment and supervision of persons who work with children
- investigation of allegations concerning persons who work with children.

LSCB's oversee how the children's workforce in their area are supported to keep children safe. This includes the development of an [When you](#) have a concern about a child being at risk of harm you make a referral to MASH. If the referral relates to a potential child protection matter, then a strategy meeting will be called (if this is not possible due to time constraints then as a minimum a telephone discussion must be had).

The purpose of this meeting is to consider the referral, share information about the child and the family in a confidential environment and make decisions about whether children protection enquiries are required, and what the plan for these enquiries should be. All strategy meetings should as a minimum have Police, Social Care and health with other agencies attending as appropriate. You may be asked to attend a strategy meeting and

you will be expected to share information held by your agency as well as taking an active role in the discussions about what happens next.

Child protection enquiries

Also known as s47 enquiries (after the relevant section of the Children Act 1989), Social Care will be the lead agency for undertaking and completing the assessment that forms the backbone of the enquiries. All agencies who have involvement with the child and family will be expected to contribute to the assessment. The assessment will look at all the children in the household and assess level of need and risk.

The outcome of child protection enquiries can be as follows:

- Concerns not substantiated – i.e. there is no information to back up the initial concerns. This does not mean that other needs will be ignored, but that there is no continuing need for the child protection process
- Concerns substantiated but child not suffering or likely to suffer significant harm – i.e. something happened that meant the child was harmed or at risk of being harmed, but the carers have taken measures that will protect the child (e.g. the abuser has left the home). As with the previous point this does not necessarily mean that the child does not have needs that require a service, just that there are felt to be no ongoing child protection matters
- Concerns substantiated and risk of child suffering or likely to suffer significant harm – i.e. there are concerns that there is ongoing risk to

the child which needs agencies to act together to reduce the risk and bring about change. This outcome will lead to a case conference being called.

If the decision by Social Care is that there is no need for a case conference but another agency disagrees, then this decision can be challenged and a conference requested.

Child Protection Case Conference

The case conference involves the family and all the professionals involved coming together in a meeting chaired by a person independent of the case. At the meeting, everyone concerned with the child's welfare, professionals, parents, carers, young people and children will be asked to contribute their views and what they are worried about, what they feel is going well and what needs to happen for the concerns to reduce.

If you are asked to attend a child protection case conference you will be expected to know the information that your agency holds and submit this in a written report at least 3 days before the conference. At the conference you will be required to present this information verbally and then, having listened to the other information available to the meeting, form a view about whether there is a continuing risk of harm to the child.

Where the decision is that there is continuing risk, a child protection plan will be drawn up, requiring the family and involved agencies to work together to reduce the risks to the child and bring about long term change.

If the decision is that there is no continuing risk, a plan may still be drawn

up so that support is provided to the family, but the case will drop out of the child protection process.

Core Groups

Where a child is made subject of a child protection plan, a core group consisting of the child (if old enough), parents and main agencies will be drawn up. The core group will meet for the first time within 10 working days of the initial conference and then every four weeks thereafter.

Chaired by the social worker, the core group is responsible for making sure that the plan is put into action and everyone works together to reduce the risk.

If the core group feels that the risks are increasing, or that there is no change happening for the child they can request that a review conference is held early to formally review the child protection plan.

If you are asked to be part of a core group there is an expectation that you will be actively involved with the family in looking to reduce the risk and effect change.

Review Conferences

Review conferences will be held at regular intervals for all children on child protection plans, and they should be no more than 6 months apart.

The purpose of the review conference is to consider what has happened in the time since the last conference and whether progress has been made towards reducing the risk to the child.

The information the conference hears will determine whether the plan should continue for a further period of time, the plan should come to an end (if the risks have been reduced to a satisfactory level and there is lasting change) or whether

the case should be escalated and further action taken (e.g. should there be an application made to court in order to keep the child safe).

As with the initial conferences, as an attendee you will be expected to provide an update of your agency's involvement since the last meeting and form a view as to whether the plan should continue or not.

Escalation policy.

Safer care

This is ensuring opportunities for harm to occur are reduced or eliminated. Some organisations have Safer Care policies. The NHS Safer Care programme for example has the stated aim of:

to build an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients.

It is therefore important that as individuals, organisations and multi-agency groups we all take responsibility for identifying areas where there may be risk, for example through lack of knowledge, and what may be required to eliminate that risk.

Safeguarding supervision and peer support

Some agencies, such as Social Care and Health Visiting, have established supervision procedures that ensure that staff are supported on a regular basis to look at the families that they are working with and ensure that the work is appropriate and manageable.

Working Together 2015 sets out the role of supervision:

Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family.

Para 56, p. 25, Working Together 2015

Supervision also provides a platform for you to be emotionally supported in relation to the demands of your job. Supervision can be one to one or in groups.

The DSCB has an agreed set of supervision principles across the partnership, which can be accessed [on the DSCB website](#).

The supervision referred to above is formal supervision; however we often also have informal supervision. This is where you have discussion with your colleagues about a case, or a quick conversation with your manager. Such supervision can be as important as formal supervision, however there is a risk that these conversations go unrecorded. Many serious case reviews have found that corridor conversations have influenced the direction of work undertaken with a child or their family with serious consequences. It is therefore important that such conversations are recorded appropriately.

Allegations about professionals and the Designated Officer

If you have any concerns about colleagues or others in a caring capacity (paid or voluntary) then you must report these to your line manager, whatever the perceived status of the abuser. If the concern involves your line manager then you should go to the next level of management that is not implicated. The person that you report your concerns to must then follow the process for managing allegations within your organisation. If you are still concerned contact the Local Authority's Designated Officer yourself.

Allegations need to be referred to the Designated Officer within the Local Authority. The criteria are where a member of staff (including volunteers):

- behaves in a way that has harmed a child, or may have harmed a child;
- possibly commits a criminal offence against or related to a child; or

- behaves towards a child or children in a way that indicates he or she would pose a risk of harm to children

The role of the Designated Officer is not to investigate, but to ensure that correct procedures are being followed and that, where necessary, Children's Services and the Police are involved.

The guidance highlights the procedures for dealing with allegations need to be applied with thought and judgement as many cases may not meet the above criteria or warrant involvement of the Police or Children's Services. In these cases local arrangements should be followed.

If you are subject of an allegation, employers have a duty to support you and keep you informed of the progress of any subsequent investigation. If you are subject of an allegation then you should seek contact with your trade union / professional body straight away.

Whistleblowing

Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality or risk in the organisation (for example, crimes, civil offences, miscarriages of justice, dangers to health and safety), and/or the cover up of any of these. The malpractice has a public interest aspect to it, usually because it threatens others. It applies to raising a concern within the organisation as well as externally, such as to a regulator.

Whistleblowing to Ofsted about safeguarding in local authority children's services, Ofsted 2014

Approach your line manager with your concern, either verbally or in writing, unless the concerns relate to your line manager (then approach a more senior manager). If you feel your organisation:

- will cover it up,
- would treat you unfairly if you complain, or
- hasn't sorted it out after you told them

contact a '[prescribed person](#)' or body.

Read your organisation's whistleblowing policy. This may be a difficult decision to make, but keep children at the centre of your decisions and as long as you act in the reasonable belief that you are raising the concern in good faith you must be protected from reprisals of victimisation.

The NSPCC run a [whistle blowing advice line](#) in relation to child protection – this can be contacted on 0800 028 0285

Culture of openness

William Vahey, a prolific sex offender, was able to obtain employment at a school in London. The [Serious Case Review](#) following the discovery of the abuse that he had perpetrated at the school found that whilst there were aspects of his behaviour that should have alerted senior staff these were never looked into. The review found that Vahey was in effect 'hiding in plain sight'. Immediately from the point of his employment he started to undertake certain actions (e.g. having children alone in his room), in effect normalising the behaviour.

The review found that Vahey not only groomed children but groomed the staff as well, assuming a great deal of power and influence in the school. Therefore whilst individuals had concerns, these were never taken further – this being despite the review finding some pupils referred to him as 'paedo Vahey'.

If you have concerns about the actions of a colleague, speak to your line manager or designated

safeguarding lead. If you work in a school speak to either the headteacher or, if the concerns relate to the headteacher, the Chair of Governors.

Be prepared to think the unthinkable.

Recording

Throughout our day we have a lot of interaction with children and families as well as discussions with colleagues and other professionals. It is important that all this work is recorded, but it is also important that it is done succinctly. Your records are used for:

- Supporting effective partnerships with users and carers.
- Assisting continuity when workers are unavailable or change.
- Providing a documented account of your agency's involvement with an individual service user.
- Providing evidence for planning and allocating resources at an individual and strategic level.
- Facilitating reflection, analysis and planning.
- Supporting supervision and professional development.
- Recording that the practitioner and agency have met the expected standards.

Chronologies

An effective chronology can be used by practitioners as a tool when working with children and families, allowing an understanding to develop of the impact of events in the life of the child. Analysis of a chronology can provide insight into both the immediate and long-term effects of these individual events on a child's emotional and physical development. An example of when a chronology can be a powerful tool is in cases where there is suspicion of neglect. With neglect there is not necessarily an identifiable point when the case moves to child protection, and often incidents are seen in isolation of each other. A chronology allows for patterns to be seen and for change or lack thereof to be recorded.

Chronologies should:

- be accurate – contain fact, not opinion
- contain sufficient details but not replicate the case recording (i.e. pertinent information only)
- be flexible – allow for unplanned events to form part of the recording
- be reviewed regularly – chronologies should be up to date to allow analysis
- note action that was taken in response to any particular event (i.e. *x* happened and so we did *y*). It is also important to note if no action was taken.

Key information in chronologies should include:

- Key dates – e.g. dates of birth of important family members, deaths of important people in the child's life.

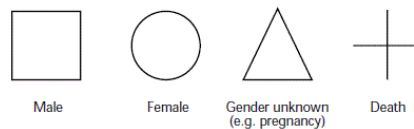
- Key professional interventions – e.g. date of initial and historical referrals to Children's Services, outcome of s47 enquiries, date of child protection plans being made.
- Significant events – e.g. child coming to school with an injury, neighbours reporting child out in early hours of the morning, significant illnesses, missing episodes, medical appointments not being kept, incidents involving the Police, issues relating to the parents.

Genograms

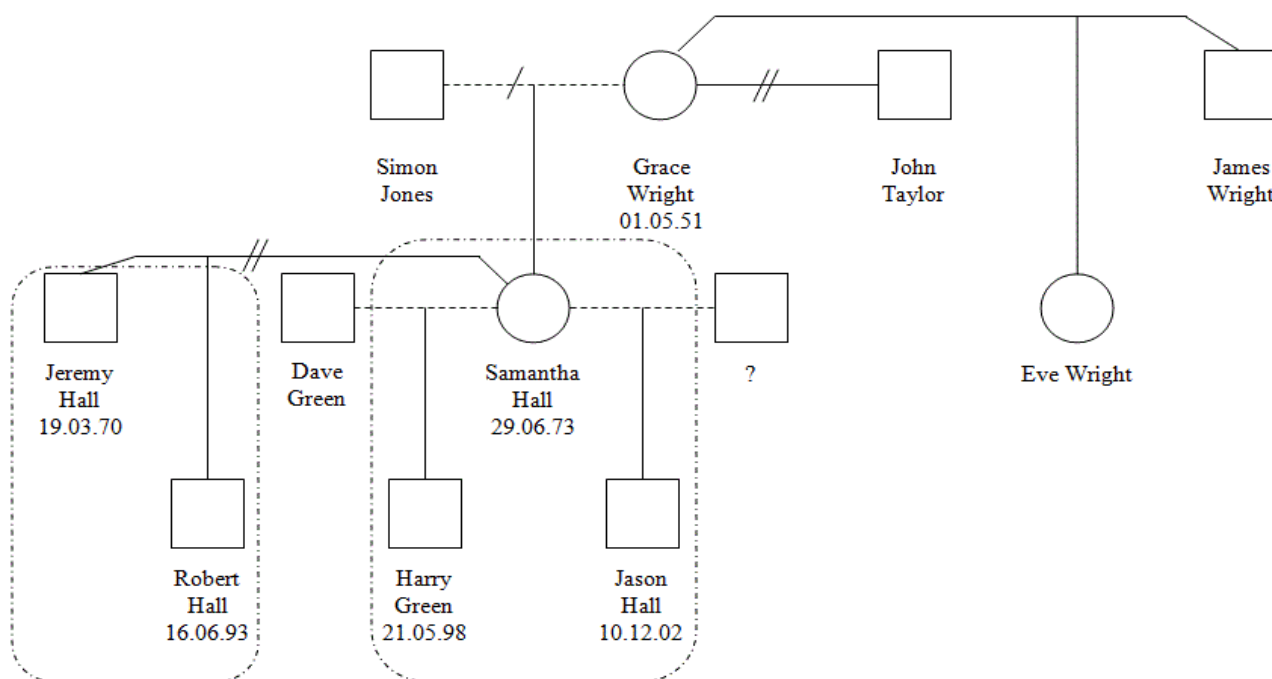
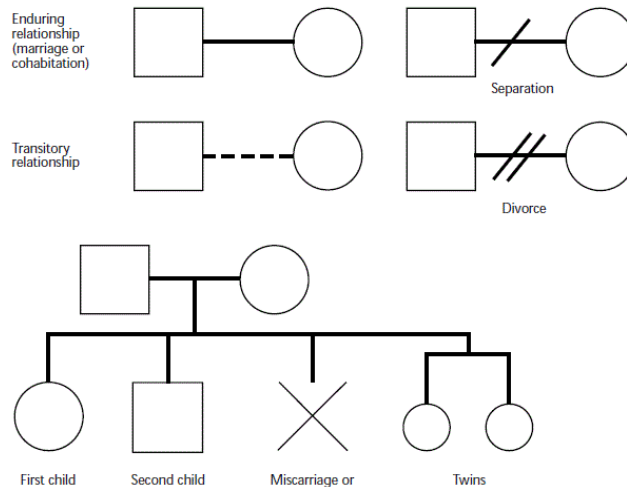
Genograms (also known as family trees) are a simple tool that allow us to see how a family is made up. An example of a genogram is shown at the bottom of this page.

A genogram can be useful for establishing who is living in the home and who is in the wider family network, and whether there is contact or not. Genograms use a common set of symbols, and these are shown to the right.

Genogram symbols



Genogram symbols



In this example therefore we can see three generations of the same family, and where possible the information includes dates of birth. Using the key (below), we can see that the maternal grandmother had two enduring relationships, one of which ended in divorce, and one transitory relationship. The mother has had three relationships resulting in three children, the father of the youngest not being known. Where it is shown that relationships have ended (through separation or divorce), the lines that show this can also be used to show who the child(ren) from the relationship live with. Therefore in this example it can be seen that Jeremy Hall's marriage to Samantha has come to an end, but that their son, Robert, lives with his father.

A dotted line around all the people who live in the same household can help further.

Courts

Courts are divided into Magistrates Courts and Crown Courts. All cases will initially be heard in the local Magistrates Court and, dependent on the type and seriousness of the matter before the court, a decision will be made as to whether the case can remain in the Magistrate Court or should be transferred to Crown or High Court – this applies to criminal and family law.

Standards of proof are different dependent on whether you are in a criminal court or family court:

- Criminal court – standard of proof is that the defendant is guilty beyond reasonable doubt, with the burden of proving this being on the prosecution
- Family court – the standard of proof is the balance of probability, e.g. in an application for a care order the local authority must prove that, on the balance of probability, the parent / carer breached their duty of care for the child causing them significant harm

Being a witness

If you are called to give evidence in court as a professional involved with a child or family, you should seek advice and support from both your line manager and where necessary your agency's legal team.

If it is the first time that you have been to court, arrive early and ask whether you can be shown the layout of the court so that you can get your bearings. If you are nervous about giving evidence then you can ask for a colleague or manager to support you, however only you will be allowed in the witness box.

If you are called to give evidence the following will happen:

1. You will be shown to the witness box
2. You should stand up, unless you find standing difficult in which case you can ask the judge or magistrate if you can sit down
3. You will be asked to take an oath or affirm that you will tell the truth. This will be in line with your religious beliefs
4. Whoever has asked you to attend court will ask questions first with the other parties asking questions afterwards.

The Crown Prosecution Service give the following things to remember:

- It is not personal – invariably the lawyers will be trying to make sure you have not made a mistake
- You are not on trial – if the questions become too aggressive the lawyer who asked you to give evidence has a right to ask for questions to be changed

Good court etiquette is that you face the magistrates or the judge when giving the answers to the questions you have been asked.

Once you have given your evidence, the court will tell you that you may leave the witness box. You may be told that you are released, this means that you can leave. You may be asked to stay after you have given evidence if something new comes up.

Serious Case Reviews

What is a serious case review?

Working Together 2015 requires Local Safeguarding Children Boards to undertake reviews (known as Serious Case Reviews) when a child has died or been seriously harmed as a result of abuse or neglect, and where there is cause for concern about the way agencies have worked together to keep that child safe.

The purpose of a review is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- As a consequence, to improve inter-agency working and better safeguard and promote the welfare of children.

Where a serious case review has taken place it is important that we all consider the learning that comes from it, and not just the agencies and professionals that were directly involved. Many of the issues that come up are common to a number of serious case reviews. One such example is poor interagency working, this theme dating back to the Maria Colwell Inquiry in 1974 and still being present today.

The local picture

The DSCB has published a number of serious case reviews in the last two years. Over the next few pages we look at the key points from the most recent. This provides a useful starting point, but doesn't replace reading the review itself. Links to all the reviews mentioned can be found on each page.

Where possible it is recommended that a portion of your team meetings are spent discussing these issues and the various challenges presented with a view to developing a team approach. Further guidance around this and wider agency plans can be obtained from your safeguarding lead. Many of the challenges repeat through each review, however for ease of reading they are only recorded once here.

On the last page the top ten essentials for practice derived from analysis of serious case reviews undertaken nationally.

For further information about serious case reviews

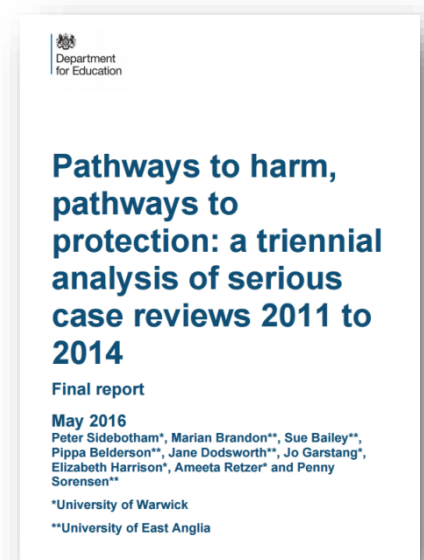
- Have a look at the [DSCB Website](#)
- Refer to [Working Together 2015](#)
- For an indication of common themes arising from serious case reviews across the country search the [NSPCC's repository of serious case reviews](#)



Serious Case Reviews – the national picture

A summary of key points from [Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014](#) (published May 2016)

- Whilst there has been an increase in the number of serious case reviews, there has been **no change in the number of child deaths linked to maltreatment**.
- The main **pressure points are when cases are “stepped-up” and “stepped-down”** from the child protection system – these are often problematic.
- Less than half of the serious case reviews revealed current involvement of Children’s Social Care, however hindsight suggests that many of the cases had been **closed too soon or with poor ongoing support** from other agencies.
- Whilst there is good awareness of risk factors, case reviews suggest that where Children’s Social Care is not involved there may be **little analysis of the risk of harm and support may drift**.
- There is good awareness of the “toxic-trio” (domestic abuse, mental health and alcohol / substance misuse) and the risks that are posed, however **other risks are less well considered** including adverse experiences in the parents’ own childhoods, a history of violent crime, a pattern of multiple consecutive partners, acrimonious separation, and social isolation.
- There is a need to move away from incident-based models of intervention with domestic abuse to a deeper understanding of **the ongoing nature of coercive control** and its impact on women and children, and also on men.
- The need to hear **the child’s voice also includes the “silent” ways** in which children may tell you about abuse (e.g. emotional and behavioural changes and outbursts).
- As identified earlier in this magazine, **an attitude of respectful uncertainty must be maintained** requiring thinking beyond the usual remit of your professional role and considering the holistic circumstances you are presented with.
- A continuing theme is of **professionals hanging back** and expecting others to act or considering their role to have ended when they passed on information.
- **Assessment is not a one off event** relying on a single visit or single sources of information, but an ongoing process which should be continuously revisited.





This review related to a five month old child who was found to have multiple fractures which were considered to be non-accidental.

Summary of case:

- Joe was born after his parents had been together for around a year, although they had known each other for some years.
- Joe's mother was estranged from her family (this having happened some 3 years before Joe was born, his mother was 19 when he was born) and was treated for depression as well as having a diagnosed eating disorder.
- Joe's father was two years younger than Joe's mother and was known to have mental health issues which had led to hospitalisation and periods of time in care of the local authority prior to living with his grandmother on a Residence Order.
- The family home was known to be fractious, however professionals were positive about the care Joe was receiving.
- Joe's father was known to have been involved in a number of incidents where he had allegedly threatened family members with varying acts of violence.
- Prior to the discovery of the fractures, Joe had had several different encounters with emergency health services including Minor Injuries and Devon Doctors.

Findings of the review:

- 1) Information that emerges through pregnancy must be considered as part of the wider picture – in this case incidents were seen in isolation meaning that concerns were not identified.
- 2) Information about incidents involving the wider family was not considered in relation to how it may impact on the baby (both pre and post birth).
- 3) Professionals did not challenge their pre-formed view that Joe was not at risk of harm – this being based on parents being co-operative, engaged with services and having reasonable explanations for their behaviour. This also meant that other work then took priority as other children were seen as being more "at risk".

Key challenges to all practitioners identified from the review:

- Do you know how to **access the South West Child Protection Procedures**? Do you follow these or have local protocols that set out different processes? **Do local processes follow the agreed procedures?**
- Do you routinely **update chronologies**? If new information came to light would this prompt you to **reconsider what you already know**?
- **What is life like for the child** in the family home? How do you know this? **What evidence supports your view?**
- Do you form a decision and stick to it? Or do you **reappraise your decisions with every visit / new piece of information**?
- How do you challenge yourself? Are you **able to reflect** on decisions? Does supervision provide you with the space to critically appraise your decisions?
- How do you **share information with colleagues** – is this in a **timely manner**, ensuring that they can follow-up if required?

This serious case review was undertaken by Lancashire Safeguarding Children Board. It is included here as the child and its mother lived in Devon for a period of time prior to the death of Child O aged 22 months. The review poses challenges for professionals in Devon as well as elsewhere in the country. The following is taken from the associated learning briefing:

Background

This was a review which encompassed five LSCBs, as the mother and child had been moving around all the authorities. It is possible to speculate on the mother's motivation for all the moves, but we do not know it. It is likely that the moves were prompted by the fear of being found by either the child's father or the authorities. In August 2014, the mother killed Child O and then herself. It was a tragic and highly unusual incident. At the time of death, Child O was 22 months old.

The court process related to father's application for contact with Child O. Mother had removed herself and Child O from cohabiting with father when Child O was a tiny baby. Whilst the couple were together, she had made one allegation of domestic abuse. Police had attended and recorded verbal abuse. Once she had left, she stayed hidden from all agencies, moving around the country. Later after the separation she made other serious allegations, but had been unable to offer any evidence when the Police investigated. The family thus had very limited involvement with professionals. The only agency involved at the time of Child O's death was Cafcass.

Findings:

- **Working with fathers:** The importance of working proactively with fathers was emphasised. It is possible that assumptions regarding the role of fathers affected professionals in this case.
Practice questions: Have I made assumptions about the role of fathers? Have I heard the views of fathers?
- **Ensuring that the impact on children is taken into account in assessment and decision-making:** It appeared that the child was lost in the parental dispute and that decisions did not sufficiently consider the outcomes for the child.
Practice questions: Do I know what a day in the life of this child is like? Have I considered the impact on this child of my decisions?
- **Dealing with allegations of domestic abuse:** In this case, the mother told professionals of increasing levels of domestic abuse, describing abuse of increasing severity as time went on. However, there are significant concerns that this was untrue.
Practice questions: How do we make sure we respond appropriately to allegations of domestic abuse? Do we ever question whether domestic abuse allegations are true?
- **Homicide in the context of parental conflict:** This is an issue which is the subject of new research.
Practice questions: do we know the research on homicide in the context of parental conflict? Are we aware of the warning signs?

Focus On

Serious Case Reviews – What can we learn?

Top ten practice essentials when working with children and families, based on analysis of case reviews nationally over the last few years:

- ✓ Always see the child alone on a regular basis – and overcome any communication difficulties that might prevent effective assessment and care
- ✓ Always think of the additional risks to young babies and children and ensure physical examination, where necessary, by one of the professional team
- ✓ Always see the accommodation occupied by the child
- ✓ Always identify who is in the household, including any new partners and ensure that there is contact with the men involved
- ✓ Always seek information on families from the other professional colleagues involved with them, and on a regular basis
- ✓ Do not allow families to block access – seek management, and, if necessary, police support
- ✓ Always ensure the best possible understanding of family histories – use chronologies to underpin that understanding
- ✓ Always look at the build-up of cumulative evidence of neglect or mistreatment
- ✓ Always be clear with parents about your first responsibility being the welfare of the child – and explain the consequences of their actions
- ✓ Always think of the family circumstances from the child's point of view

Kennedy, J. 2014. *Serious Case Reviews: the Report of the Expert Panel, the Way Forward, and Our Top Ten Tips for Protective Practice*. Pavilion, London

