The Safeguarding Magazine

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For more information see
https://dialogueltd.co.uk/magazine

About the providers

Devon Safeguarding Children Board

Children in Devon are best safeguarded when key agencies work together effectively. Devon Safeguarding Children Board (DSCB) is designed to help ensure that this happens.

The core membership of Safeguarding Children Boards is set out in the Children Act 2004 and includes representatives from local authorities, health, police, education and others including the voluntary sector. The objective of the Board is to coordinate and ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children living in Devon.

dialogue

dialogue was created by John Woodhouse, a social worker and former senior manager who has senior management experience in local authority and private sector. He has direct experience of managing and turning around safeguarding teams, managing and quality assuring services for children with disabilities and providing high quality training for the Devon Safeguarding Children Board, amongst others.

Our aim is to facilitate the cycle between learning and practice, so courses bring to life law, research and policy with live and recent material.

Please note:

We aim for the information in this magazine to be up to date and correct, however things may change following publication.

> “Everyone who works with children – including teachers, GPs, nurses, midwives, health visitors, early years professionals, youth workers, police, Accident and Emergency staff, paediatricians, voluntary and community workers and social workers – has a responsibility for keeping them safe.”

Welcome

Welcome to the latest version of the magazine. We have been getting lots of positive feedback – several organisations are printing a few copies and leaving them around for all staff to browse. Get in touch with your ideas for content or spreading the word… magazine@dialogueltd.co.uk

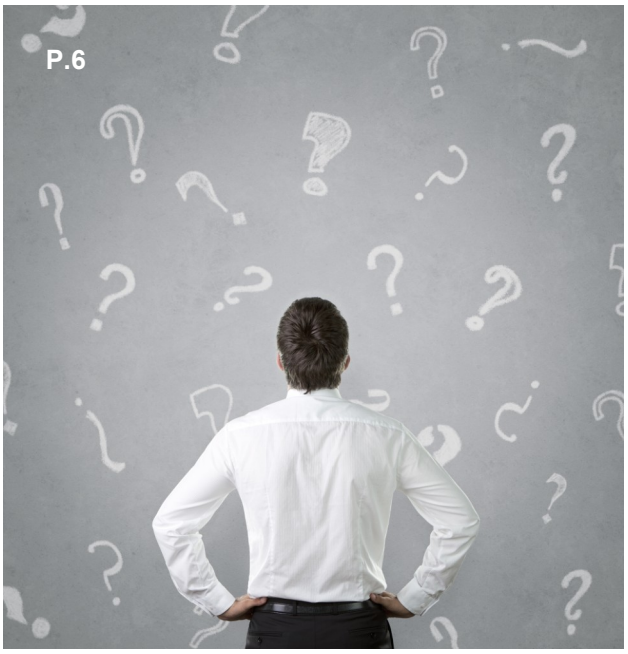
The magazine provides basic information on all the areas you need to know to meet the training requirements of the NHS Intercollegiate document and Working Together. Each article will provide a short introduction with links to further reading if you want to find out more, or links to local services should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



Getting the right support

Child Protection

Example only — for completion

Knowledge base

Example only — for completion

Focus on …

Example only — for completion

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.

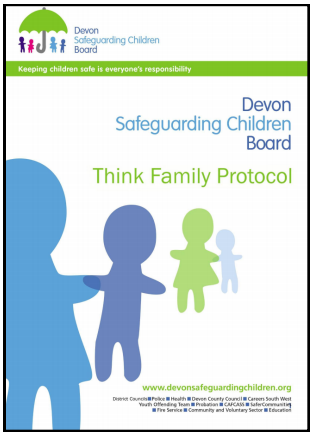
Throughout all of this we must work to ensure we keep children and their parents at the centre of what we do. The more complicated the family situation, the harder this can be to achieve.

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.

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

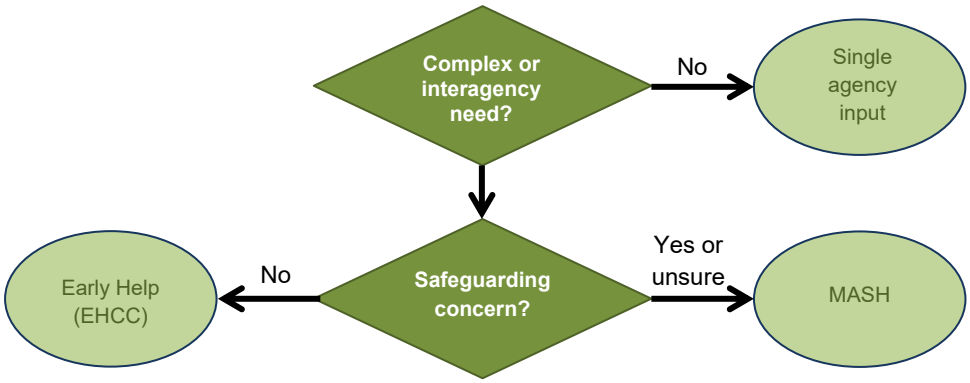
The protocol is clear that where joint assessment is required, Children's Services will be the lead agency but work closely with other agencies with close planning from the outset.

For more information see the Think Family Protocol.

Read the **Think Family Protocol** and book on Think Family training on the **DSCB website**

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.



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.

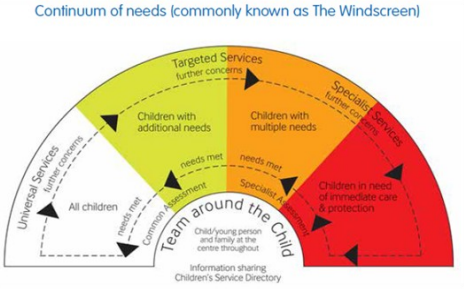
MASH—If you have a safeguarding concern on a child not already open to children's services, you should complete a written enquiry to the multi-agency safeguarding hub (MASH). You'll need to think about getting consent to this – there's more guidance on this later in the magazine and guidance on filling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

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

You can learn more about early help on our **elearning course**

Threshold tool

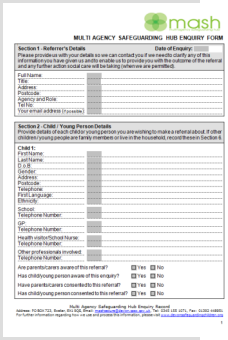
This tool is designed to help us understand the needs of Devon's children, to think through who should be involved and to clarify when to take action. It has examples of need at each level to help you determine how to respond.



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.

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


mash
MULTI AGENCY SAFEGUARDING HUB ENQUIRY FORM

- 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.

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).

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?

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.

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.

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'.

Interagency 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 information in this section provides 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

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**

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.

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**

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.