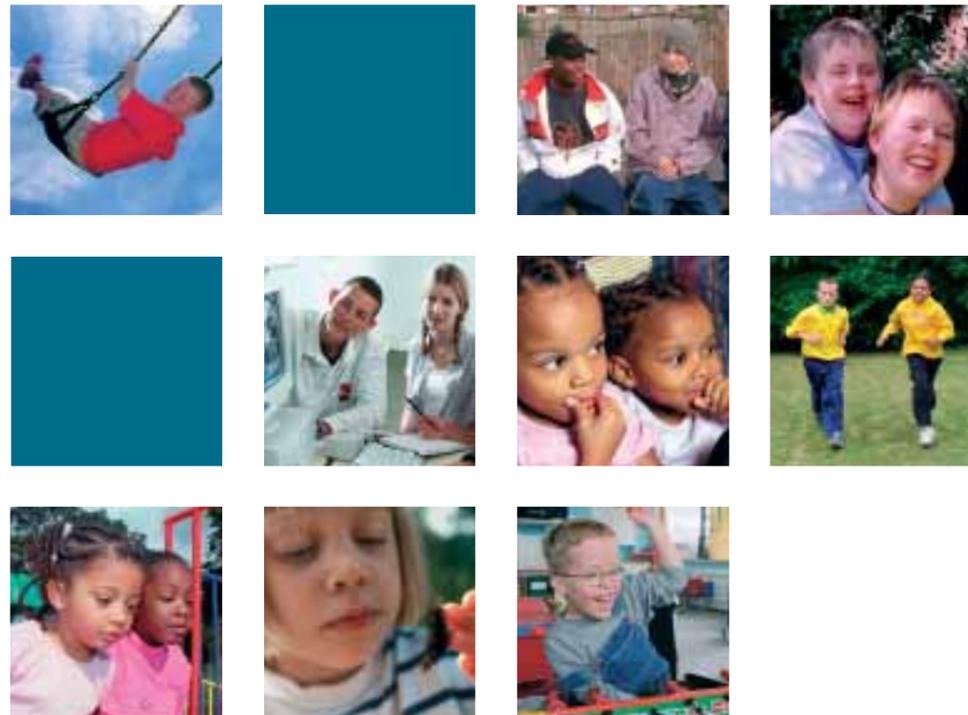


# What to do if you're worried a child is being abused



Every Child Matters  
Change For Children



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# Preface – Safeguarding Children



This practice guidance has been developed to assist practitioners to work together to safeguard and promote children’s welfare. It is for anyone whose work brings them into contact with children and families, but particularly those who work in early years, social care, health, education, schools and criminal justice services. It is relevant to those working in the statutory or the independent sector, as well as to members of the wider community, and applies to all children and young people **irrespective of whether they are living at home with their families and carers or away from home. This includes young people over the age of 16 years who are members of the Armed Forces, in hospital, prison or Young Offenders’ Institutions.** Where children are living in foster care or in an institutional setting, including custody, assessments and decisions about further action should also include consideration of the role of the responsible carers, residential or custodial staff as well as parents and other family members. The document recognises that concerns about a child’s welfare can vary greatly in terms of the nature and seriousness of those concerns, how those concerns have been identified and over what duration they have arisen. By ensuring that such concerns are appropriately shared with statutory agencies and other individuals responsible for safeguarding children within agencies, the welfare of children and the safeguards provided for them will be enhanced.

The document focuses on:

- what you should do if you have concerns about children in order to safeguard and promote the welfare of children, including those who are suffering, or at risk of suffering, significant harm;
- what will happen once you have informed someone about those concerns;
- what further contribution you may be asked or expected to make to the processes of assessment, planning, working with children, and reviewing that work, including how you should share information;

- some basic information and background about the legislative framework within which children's welfare is safeguarded and promoted (Appendix 2).
- Appendix 3 reproduces the Government's practice guidance *Information sharing: Practitioners' guide* (2006c). It is designed to assist you when making decisions about consent, confidentiality and information sharing. References to the relevant Government Guidance on safeguarding and promoting the welfare of children are to be found on pages 71–72.
- To give practitioners confidence to apply the guidance in practice, it is important that they have:
  - a systematic approach within their agency to explaining to children, young people and families when they first access the service, how and why information may be shared, which will build the confidence of all involved;
  - clear systems, standards and protocols for sharing information. These may derive from their agency's policies, any local protocols in place, or from their professional code of conduct;
  - access to training where they can discuss issues which concern them and explore case examples with other practitioners;
  - a source of advice and support on information sharing issues.

This publication is issued by HM Government. **It summarises briefly the key processes but does not replace *Working Together to Safeguard Children* (2006a) or the *Framework for the Assessment of Children in Need and their Families* (2000).**

# Introduction – Working with children about whom there are child welfare concerns



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

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

## What is a child in need?

2 Children who are defined as being 'in need', under the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services (s17(10) of the Children Act 1989) plus those who are disabled. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are what will happen to a child's health or development **without services**, and the likely effect the services will have on the child's standard of health and development.

## What does safeguarding and promoting the welfare of children mean?

3 Safeguarding and promoting the welfare of children is defined for the purpose of statutory guidance under the Children Acts 1989 and 2004 respectively as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

## What is significant harm?

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

## What is abuse and neglect?

4.2 Abuse and neglect are forms of maltreatment – a person may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children and young people may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.

- **Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
- **Emotional abuse** is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued

only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

- **Sexual abuse** involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual on-line images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.
- **Neglect** is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born it may involve a parent failing to:
  - provide adequate food, clothing and shelter (including exclusion from home or abandonment)
  - protect a child from physical and emotional harm or danger
  - ensure adequate supervision (including the use of inadequate care-givers)
  - ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

## The processes for safeguarding children

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

**6** The flow charts in this document (pp16-20) illustrate the processes for safeguarding and promoting the welfare of children:

- from the point that concerns are raised about a child and are referred to a statutory agency that can take action to safeguard and promote the welfare of the child (flow chart 1);
- through an initial assessment of the child's situation and what happens after that (flow chart 2);
- taking urgent action, if necessary (flow chart 3);
- to the strategy discussion, where there are concerns about the child's safety, and beyond that to the child protection conference (flow chart 4); and
- what happens after the child protection conference, and the review process (flow chart 5).

## Child welfare concerns...

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

## In general

**8** All those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to safeguarding children, have a duty to safeguard and promote the welfare of children. You are likely to be involved in three main ways:

- you may have concerns about a child, and refer those concerns to children's social care or the police. School staff (both teaching and non-teaching) should be aware of the local procedures to be followed for reporting concerns about a particular child. This will normally be via the school's designated senior member of staff or their nominated deputy or if neither are available, another senior member of the school's staff. In emergencies, however, contact the police direct;
- you may be approached by children's social care and asked to provide information about a child or family or to be involved in an assessment. This may happen regardless of who made the referral to children's social care;
- you may be asked to provide help or a specific service to the child or a member of their family as part of an agreed plan and contribute to the reviewing of the child's progress.

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

### All practitioners working with children and families should...

**10.1** Be familiar with and follow your organisation's procedures and protocols for promoting and safeguarding the welfare of children in your area, and know who to contact in your organisation to express concerns about a child's welfare.

**10.2** Remember that an allegation of child abuse or neglect may lead to a criminal investigation, so don't do anything that may jeopardise a police investigation, such as asking a child leading questions or attempting to investigate the allegations of abuse.

**10.3** If you are responsible for making referrals, know who to contact in police, health, education, school and children's social care to express concerns about a child's welfare.

**10.4** Refer any concerns about child abuse or neglect to children's social care or the police.

**10.5** Have an understanding of the *Framework for the Assessment of Children in Need and their Families* (see Figure 1), which underpins the processes of assessing needs, planning services and reviewing the effectiveness of service provision at all stages of work with children in need and families. (The dimensions of the Common Assessment Framework (2006b) are based on those in the Assessment Framework.)

**10.6** When referring a child to children's social care you should consider and include any information you have on the child's developmental needs and their parents'/carers' ability to respond to these needs within the context of their wider family and environment. This information may have been obtained during the completion of a Common Assessment (2006b). Similarly, when contributing to an assessment or providing services you should consider what contribution you are able to make in respect of each of these three domains. Specialist assessments, in particular, are likely to provide information relevant to a specific dimension, such as health, education or family functioning.

**10.7** See the child and ascertain his or her wishes and feelings as part of considering what action to take in relation to concerns about the child's welfare.

**10.8** Communicate with the child in a way that is appropriate to their age, understanding and preference. This is especially important for disabled children and for children whose preferred language is not English. The nature of this communication will also depend on the substance and seriousness of the concerns and you may require advice from children's

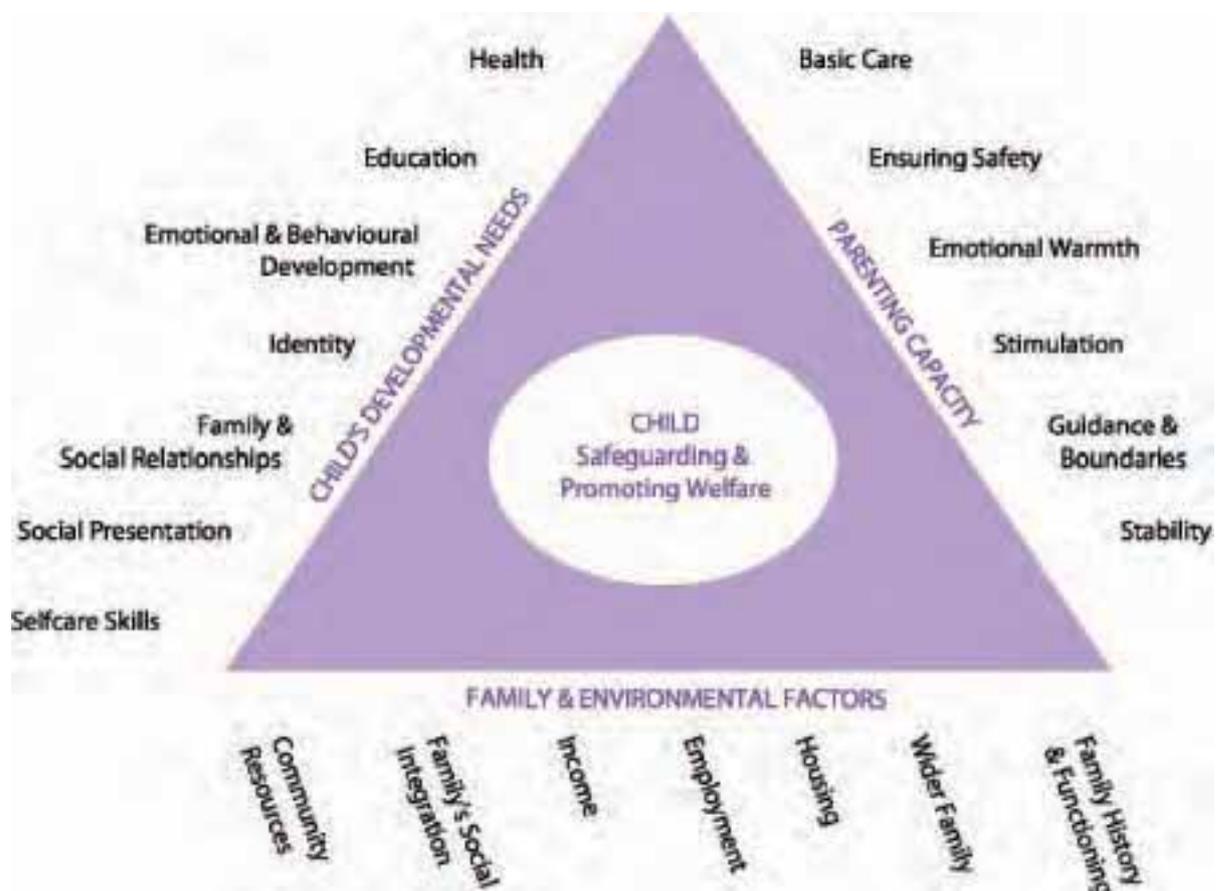
social care or the police to ensure that neither the safety of the child nor any subsequent investigation is jeopardised. Where concerns arise as a result of information given by a child it is important to reassure the child but not to promise confidentiality.

**10.9** Record full information about the child at first point of contact, including name(s), address(es), gender, date of birth, name(s) of person(s) with parental responsibility (for consent purposes) and primary carer(s), if different, and keep this information up to date. In schools, this information will be part of the pupil’s record.

**10.10** Record in writing all concerns, discussions about the child, decisions made, and the reasons for those decisions. The child’s records should include an up-to-date chronology, and details of the lead worker in the relevant agency – for example, a social worker, GP, health visitor or teacher.

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

**Figure 1: Assessment Framework**



# If you have concerns about a child's welfare...



## All practitioners should...

**11.1** Discuss your concerns with your manager, named or designated health professional or designated member of staff, depending on your organisational setting. If you still have concerns, you or your manager could also, without necessarily identifying the child in question, discuss your concerns with senior colleagues in another agency in order to develop an understanding of the child's needs and circumstances.

**11.2** If, after this discussion, you still have concerns, and consider the child and their parents would benefit from further services, consider which agency, including another part of your own, you should make a referral to. If you consider the child is or may be a child in need, you should refer the child and family to children's social care. This may include a child whom you believe is, or may be at risk of suffering significant harm. If your concerns are about a child who is already known to children's social care, the allocated social worker should be informed of your concerns. In addition to children's social care, the police and the NSPCC have powers to intervene in these circumstances.

**11.3** In general, seek to discuss your concerns with the child, as appropriate to their age and understanding, and with their parents and seek their agreement to making a referral to children's social care unless you consider such a discussion would place the child at an increased risk of significant harm. Appendix 3 reproduces the text of *Information sharing: Practitioners' guide* (HM Government, 2006c). In particular, Section 4 of this Guide provides further guidance on consent and on the circumstances when it might or might not be appropriate to discuss these matters with children.

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

**11.5** If you make your referral by telephone, confirm it in writing within 48 hours. Children's social care should acknowledge your written referral within one working day of

receiving it, so if you have not heard back within 3 working days, contact children's social care again.

## **Social workers and their managers, in responding to a referral, should...**

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

**12.2** If you and your manager decide that you should take no further action at this stage, tell the referrer of this decision and the reasons for making it. Where a referral has been received from a member of the public, do this in a way that is consistent with respecting the confidentiality of each party.

**12.3** New information may be received about a child or family where the child or family member is already known to children's social care. If the child's case is open, and there are concerns that the child is or may be suffering harm, then a decision should be made about whether a strategy discussion should be initiated. It may not be necessary to undertake an initial assessment before deciding what to do next. It may, however, be appropriate to undertake a core assessment or to update a previous one, in order to understand the child's current needs and circumstances and inform future decision-making. If this information causes you to be concerned about a child's safety then discuss it with your manager. If you consider the child is or may be suffering harm, decide whether, as the child and family will be well known to children's social care it is appropriate to hold a strategy discussion without undertaking an initial assessment.

**12.4** You and your manager should consider whether a crime may have been committed. If so, discuss the child with the police at the earliest opportunity, as it is their responsibility to carry out any criminal investigation in accordance with the agreed plan for the child.

**12.5** When you have received a referral from a member of the public, rather than another professional, remember that personal information about referrers, including anything that could identify them, should only be disclosed to third parties (including subject families and other agencies) with the consent of the referrer. If the police are involved, you will need to discuss with them when to inform the parents about referrals from third parties, as this will have a bearing on the conduct of police investigations.

## **Police officers should...**

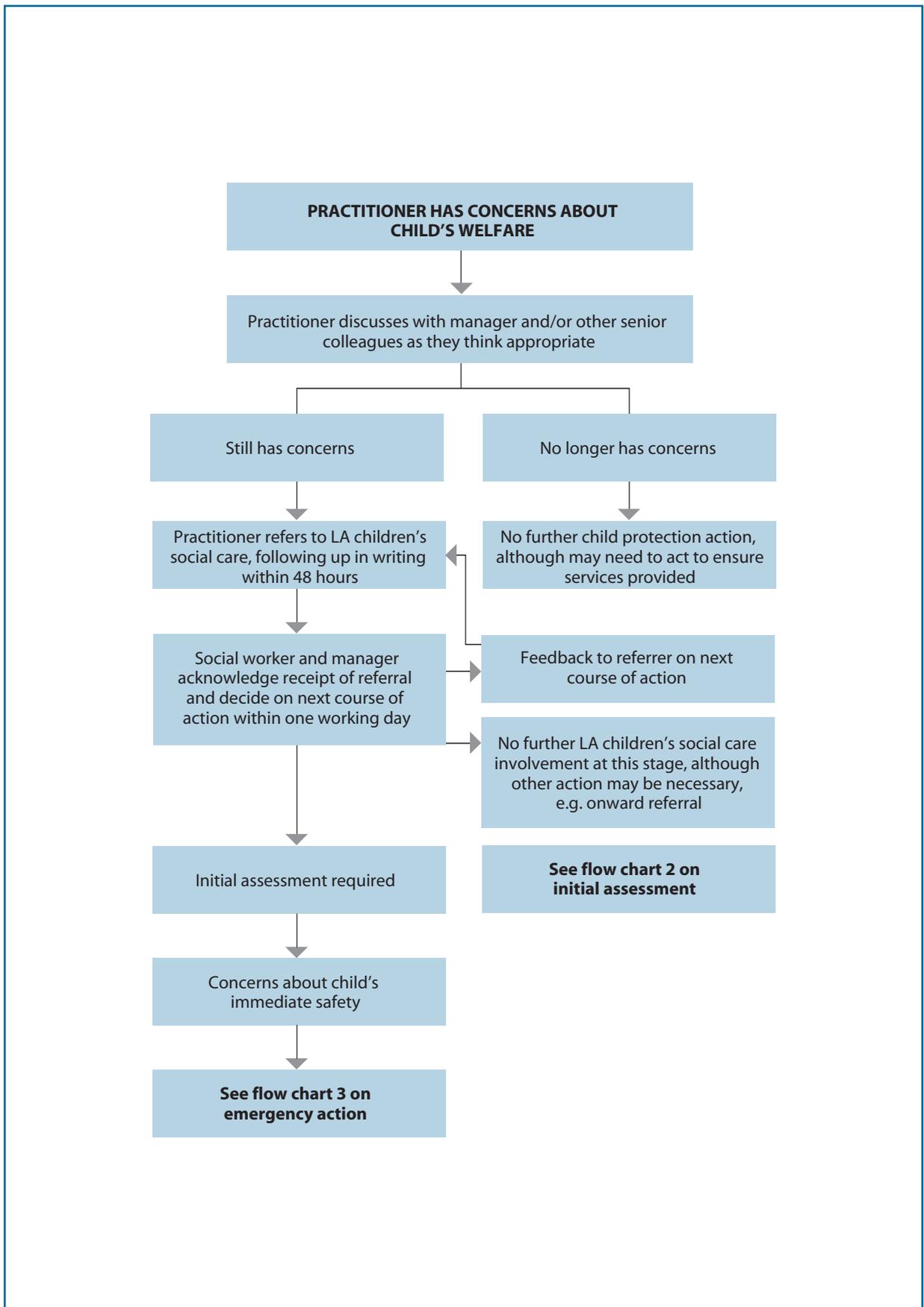
**13.1** Where you become involved with a child about whom you have child welfare concerns, refer to children's social care and agree a plan of action.

**13.2** Where you are contacted by children's social care about a child, consider whether to begin a criminal investigation and lead on any investigation.

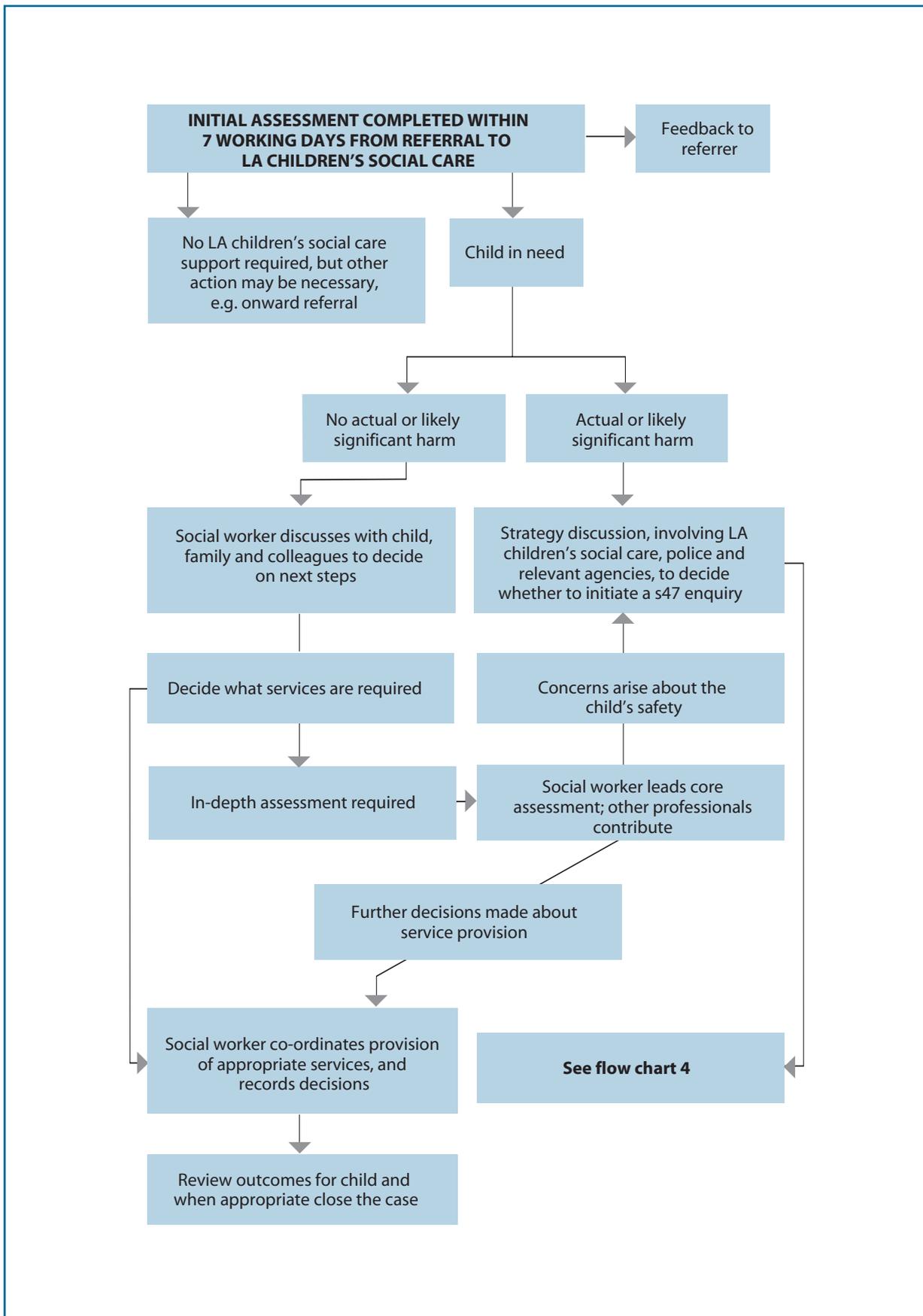
**13.3** Undertake the evidence gathering process whilst working in partnership and sharing relevant information with children's social care and other agencies.

**13.4** Take immediate action where necessary to safeguard a child, consulting with children's social care and agreeing a plan of action as soon as practicable.

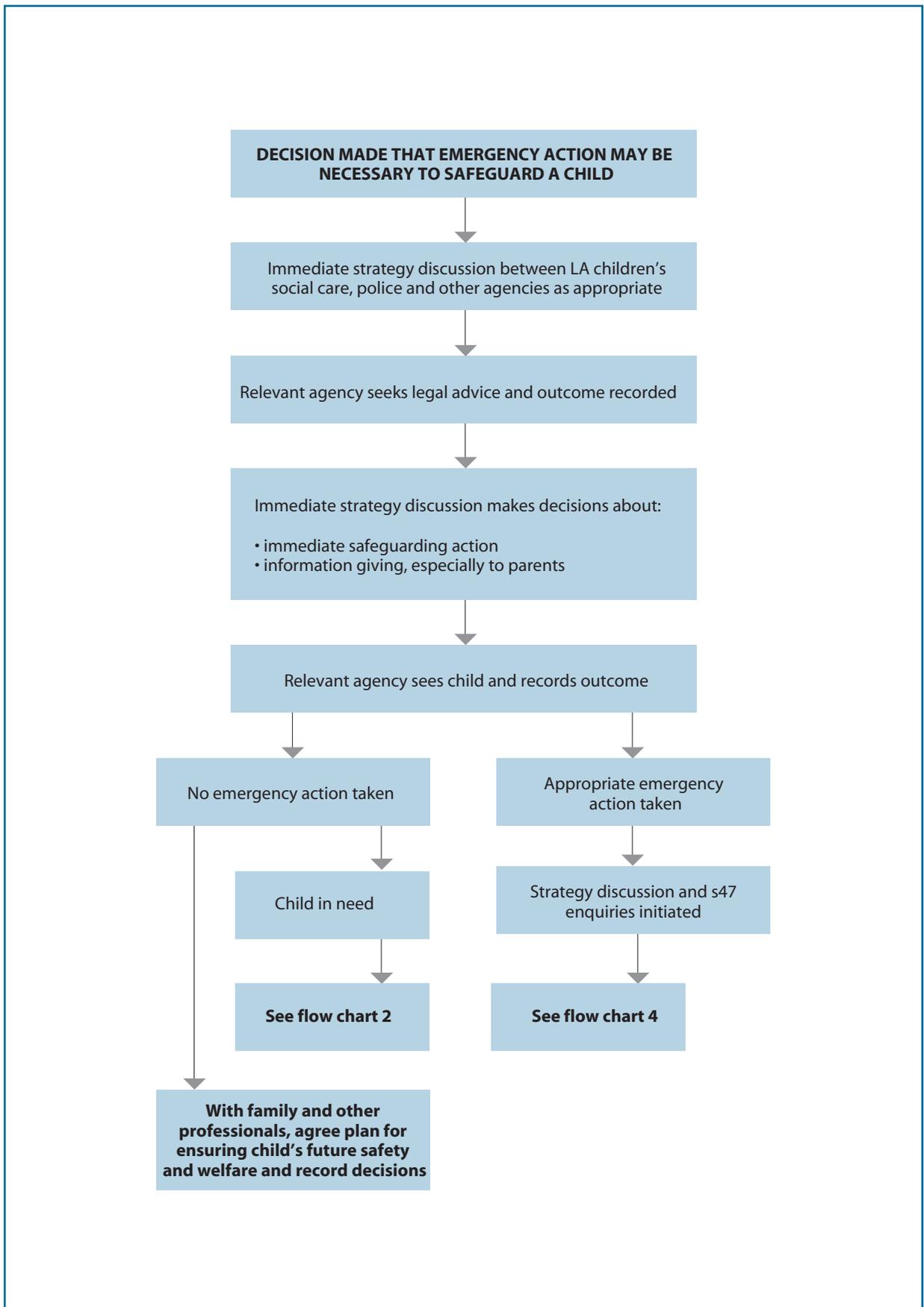
## Flow chart 1 – Referral



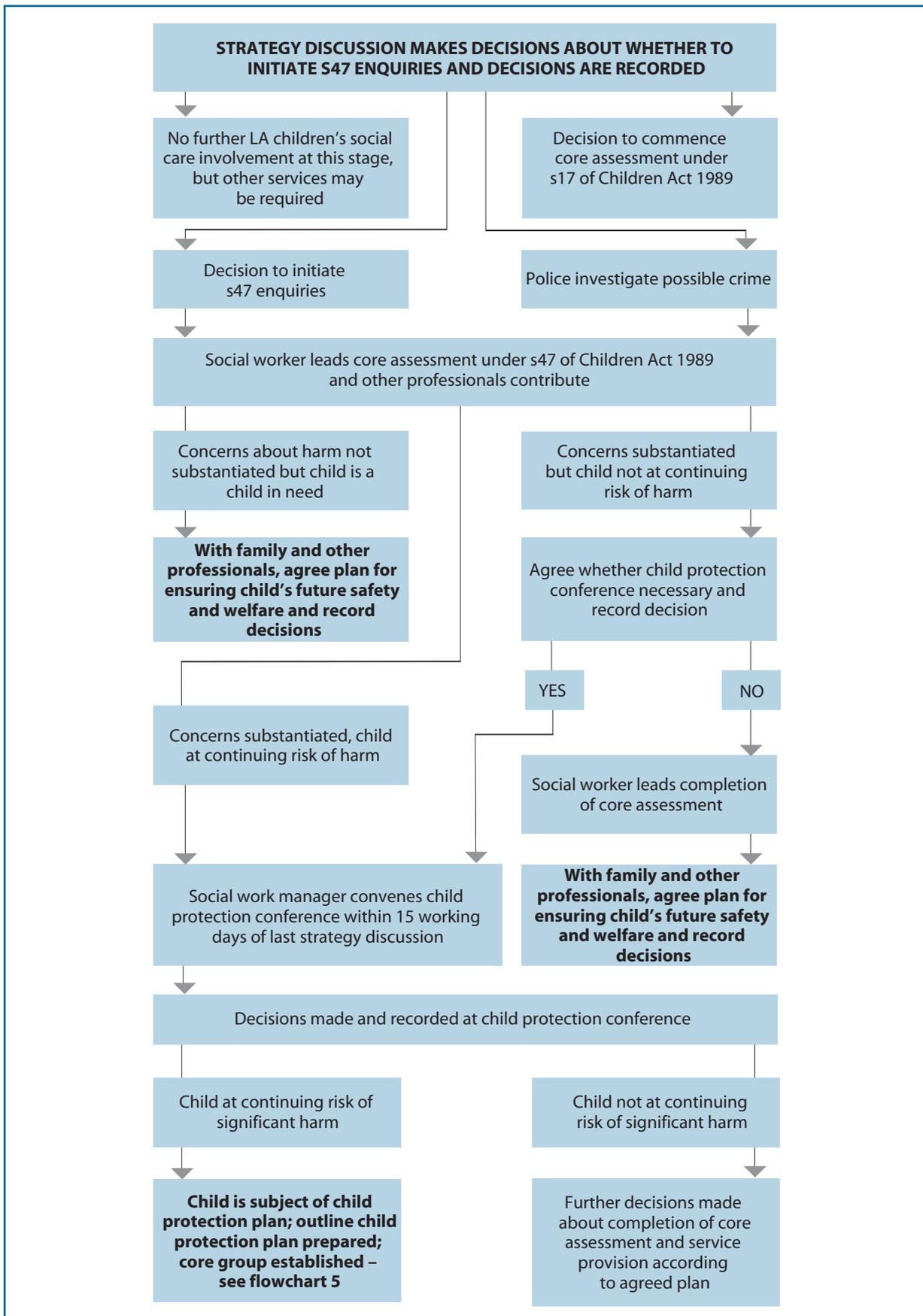
## Flow chart 2 – What happens following initial assessment?



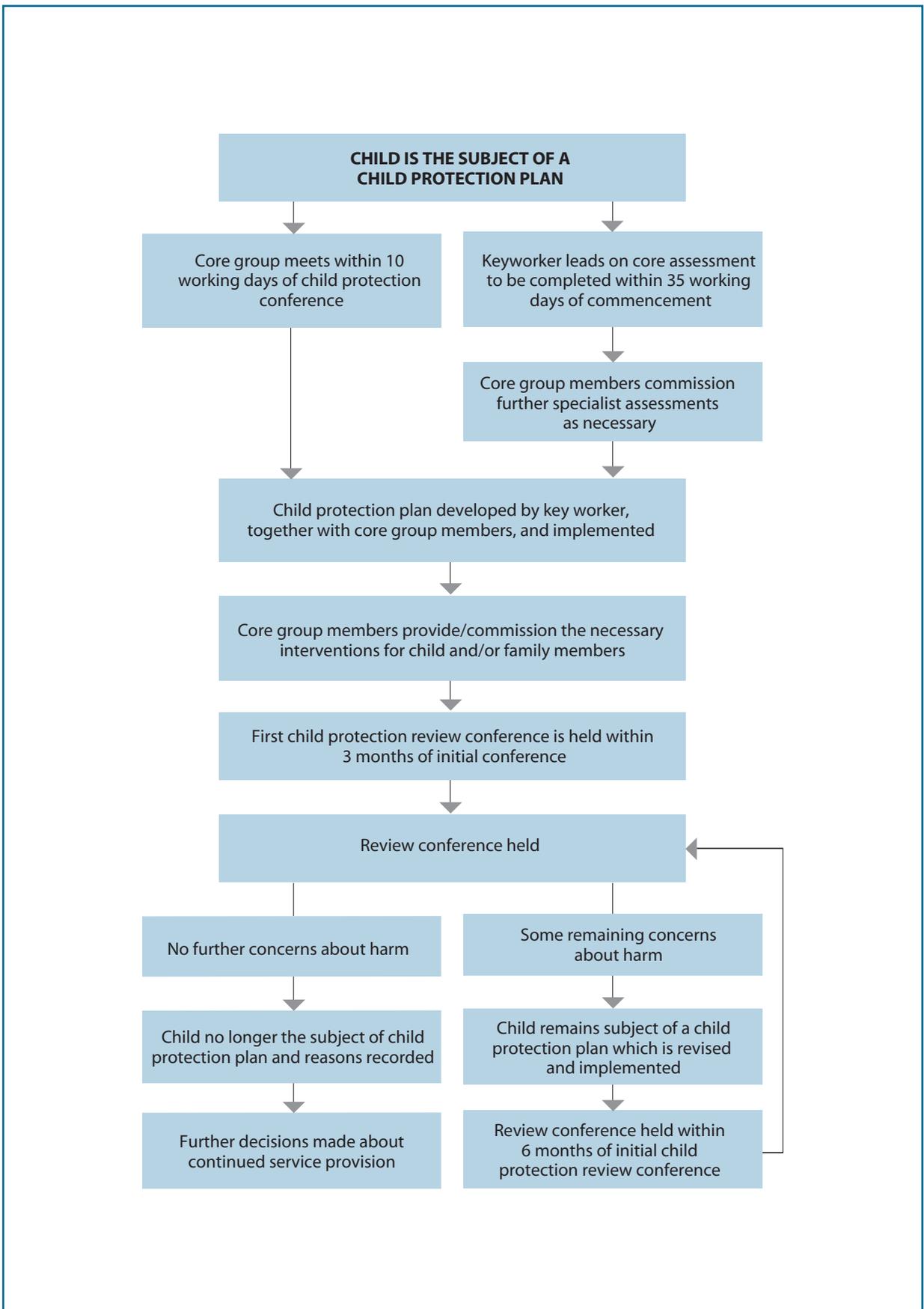
### Flow chart 3 – Urgent action to safeguard children



## Flow chart 4 – What happens after the strategy discussion?



**Flow chart 5 – What happens after the child protection conference, including the review process?**



## If an initial assessment is required...



**14** An initial assessment is a brief assessment of each child referred to children's social care to determine 'whether the child is in need, the nature of any services required, and whether a further, more detailed core assessment should be undertaken' (paragraph 3.9 of the Assessment Framework). The initial assessment should be undertaken in accordance with the Assessment Framework and where a Common Assessment has been undertaken it should build on this information. Information should be gathered and analysed within the three domains of the Assessment Framework (see Figure 1), namely:

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

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

### Social workers should...

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

**16.2** See the child within a timescale that is appropriate to the nature of the concerns expressed at referral, according to an agreed plan (which may include seeing the child without his or her carers present). This includes observing and communicating with the child in a manner appropriate to his or her age and understanding. The child's wishes and feelings should be ascertained and taken account of when planning the provision of services.

**16.3** Conduct interviews with child and family members, separately and together as appropriate. These should be undertaken in the preferred language of the child and each family member. For some disabled children and family members expertise in non-verbal

communication will be necessary. **It will not necessarily be clear whether a criminal offence has been committed**, so even initial discussions with the child should be conducted in a way that minimises distress to them and maximises the likelihood that they will provide accurate and complete information, avoiding leading or suggestive questions.

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

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

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

### **Police officers should...**

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

### **All practitioners should...**

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

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

## What happens next where there is... ...no suspected actual or likely significant harm?



### **Social workers should...**

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

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

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

## ...suspected actual harm or likely significant harm?

### **Social workers should...**

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

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

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

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

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

### Police officers should...

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

## If you need to take urgent action to protect a child...

**22** Where there is a risk to the life of a child or a likelihood of serious immediate harm, an agency with statutory child protection powers, i.e. children's social care, police or NSPCC, **should act quickly to secure the immediate safety of the child** (see paragraph 15 in Appendix 2 for a summary of statutory powers to safeguard children).

### Social workers, police officers or NSPCC workers should...

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

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

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

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

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

## If you need to have a strategy discussion...

**24** If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, children's social care should convene a

strategy discussion. Depending on the nature of the child's needs and the urgency of the situation, this might take the form of an actual meeting, or be a series of telephone conversations. In complex types of maltreatment or neglect a meeting **is likely to be** the most effective way of discussing the child's welfare and planning future action. More than one strategy discussion may be necessary. This is likely to be where the child's circumstances are very complex and a number of discussions are required to consider whether and, if so, when to initiate s47 enquiries. Such a meeting should be held at a convenient location for the key attendees, such as a hospital, school, police station or children's social care office.

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

### What are the tasks of the strategy discussion?

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

- share available information;



- agree the conduct and timing of any criminal investigation;
- decide whether a core assessment under s47 of the Children Act (s47 enquiries) should be initiated or continued if it has already begun;
- plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose;
- agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support. This will include, where a child is in hospital, making decisions about how to secure the safe discharge of the child;
- determine what information about the strategy discussion will be shared with the family, unless such information sharing may place a child at risk of significant harm or jeopardise police investigations into any alleged offence(s); and
- determine if legal action is required.

### Who should be involved in the strategy discussion?

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

- The staff involved should be sufficiently senior to be able to contribute to the discussion of information, and to make decisions on behalf of their agencies. The agencies represented should include at a minimum children's social care, the police and relevant others, including the referring agency, the child's nursery/school and health;
- If the child is a hospital patient (in- or out-patient) or receiving services from a child development team, the strategy discussion should involve the medical consultant responsible for the child's health care and, if the child is an in-patient, a senior ward nurse;
- Where a medical examination may be necessary or has already taken place a senior doctor from the providing service should be included;
- It may also be appropriate to involve the local authority's solicitor;
- It is important also to consider whether it is necessary to seek advice from, or have present, additional professionals who have expertise in the particular type of suspected maltreatment or neglect. This would enable complex information to be presented and evaluated from a sound evidence base.

## **A team manager or senior social worker should...**

- 28.1** Ensure that the strategy discussion takes place and that it considers the child's welfare and plans future actions.
- 28.2** Ensure that the discussion identifies what information will be shared with the child and family on the basis that the information is not shared if to do so may place a child at risk of significant harm or jeopardise police investigations.
- 28.3** Record the agreed decisions and actions on the Strategy Discussion Record (Department of Health, 2002c) and send this record to all relevant professionals and agencies within one working day.
- 28.4** Consider what further action is required where an Emergency Protection Order is in place or the child is the subject of police powers of protection.

## **Police officers should...**

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

## **Health professionals should...**

- 30.1** If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child.

## **All practitioners should...**

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

# **What happens when s47 enquiries are initiated?**

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

## Social workers should...

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

**33.2** In particular, see the child, ascertain his or her wishes and feelings and establish their understanding, if old enough, of their situation and the nature of their relationship with each significant family member (including all caregivers).

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

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

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

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

## Police officers should...

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

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

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

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

### **Health practitioners should...**

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

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

**35.3** Ensure appropriate follow-up of health concerns.

### **All other practitioners should...**

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

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

## What happens if after the s47 enquiries... ...concerns are not substantiated?

### Social workers should...

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

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

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

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

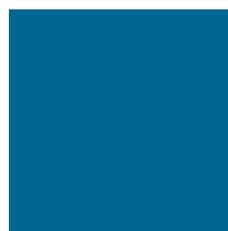
### Other practitioners should...

**38.1** Participate in these discussions and considerations when requested.

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

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

## ...concerns are substantiated, but the child is not judged to be at continuing risk of significant harm?



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

responsibility for the harm they caused the child, the family's circumstances have changed or the person responsible for the harm is no longer in contact with the child.

### **Social workers should...**

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

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

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

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

### **Children's social care managers should...**

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

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

### **Police officers should...**

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

### **Other practitioners should...**

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

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

**43.3** Request that children's social care convene a child protection conference if you have serious concerns that a child may not otherwise be adequately safeguarded.

## ...concerns are substantiated and the child is judged to be at continuing risk of significant harm?

### Children's social care managers should...

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

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

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

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

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

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

## **Social workers should...**

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

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

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

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

## **GPs and/or medical consultants should...**

**46.1** Provide a report for the child protection conference.

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

**46.3** Make every effort to attend the child protection conference.

## **All practitioners should...**

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

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

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

## What happens at a child protection conference?

**48** The conference should decide whether the child is at continuing risk of significant harm and whether, therefore, he or she requires a child protection plan to be put in place. It may be decided, where the child is not considered to be at risk of continuing harm, that she or he will not be the subject of a child protection plan. In this situation, consideration should be given to the child's needs and what future help would assist the family in responding to them. Where appropriate, a child in need plan should be drawn up and reviewed at regular intervals of no more than every six months (Paragraphs 4.33 and 4.36, Assessment Framework).

**49** Where a child becomes the subject of a child protection plan, it is the responsibility of the conference to consider and make recommendations on how agencies, professionals and the family should work together to ensure that the child will be safeguarded from harm in the future. This should enable both professionals and the family to understand exactly what is expected of them and what they can expect of others. Specific tasks include the following:

- appoint the lead agency (either a local authority or the NSPCC) and a key worker (the lead professional), who should be a qualified and experienced social worker who is a member of staff of the lead statutory agency;
- identify the membership of a core group of professionals and family members who will develop and implement the child protection plan as a detailed working tool;
- establish how the children, parents (including all those with parental responsibility) and wider family members should be involved in the ongoing assessment, planning and implementation process, and the support, advice and advocacy available to them;
- establish timescales for meetings of the core group, production of a child protection plan, and for child protection review meetings;
- identify in outline what further action is required to complete the core assessment and what other specialist assessments of the child and family are required to make sound judgements on how best to safeguard and promote the child's welfare;
- outline the child protection plan (Department of Health, 2002c), especially identifying what needs to change in order to safeguard and promote the welfare of the child. The plan should:

- identify factors associated with the likelihood of the child suffering significant harm and ways in which the child can be protected through an inter-agency plan, based on the current findings from the assessment and information held from any previous involvement with the child and family;
  - establish short-term and longer-term aims and objectives that are clearly linked to reducing the likelihood of harm to the child and promoting the child’s welfare, including contact with family members;
  - be clear about who will have responsibility for what actions – including actions by family members – within what specified timescales;
  - outline ways of monitoring and evaluating progress against the planned outcomes set out in the plan; and
  - be clear about which professional is responsible for checking that the required changes have taken place, and what action will be taken, by whom, when they have not.
- ensure that there is a contingency plan in place if agreed actions are not completed and/or circumstances change, for example if a carer fails to achieve what has been agreed, a court application is not successful or a parent removes the child from a place of safety:
    - clarify the different purpose and remit of the initial conference, the core group and the child protection review conference; and
    - agree a date for the first child protection review conference, and under what circumstances it might be necessary to convene the conference before that date.

## Pre-birth child protection conference

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

# What happens after the child protection conference if the child becomes the subject of a child protection plan?

## The named keyworker should...

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

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

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

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

## The core group should...

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

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

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

**52.4** Provide an important forum for working with parents, wider family members, and children of sufficient age and understanding. It can be difficult for parents to agree to a child protection plan within the confines of a formal conference. Their agreement may be

secured later when details of the plan are negotiated in the core group. Sometimes there may be conflicts of interest between family members who have a relevant interest in the work of the core group. The child's best interests should always take precedence over those of other family members.

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

### **All other professionals should...**

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

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

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

## **Planning**

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

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

### **The named keyworker should...**

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

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

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

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

### Other professionals should...

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

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

## Intervention

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

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

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

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

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

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

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

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

## The named keyworker should...

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

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

### **Other practitioners should...**

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

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

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

## **Child protection review conference**

**66** The purposes of the child protection review are to review the safety, health and development of the child against the planned outcomes set out in the child protection plan; ensure that the child continues to be safeguarded from harm; and consider whether the child protection plan should continue to be in place or should be changed. The reviewing of the child's progress and the effectiveness of interventions are critical to achieving the best possible outcomes for the child. The child's wishes and feelings should be sought and taken into account during the reviewing process.

**67** Every review should consider explicitly whether the child continues to be at risk of significant harm, and hence continues to require safeguarding from harm through adherence to a formal child protection plan. If not, then the child should cease to be the subject of a child protection plan. The same Local Safeguarding Children Board (LSCB) decision-making procedure should be used to reach a judgement on whether the child should continue to be the subject of a child protection plan as is used at the initial child protection conference. As with initial child protection conferences, your LSCB procedures should specify a required quorum for attendance at review conferences.

### **Children's social care managers should...**

**68.1** Ensure that the first child protection review conference is convened to take place within three months of the initial child protection conference, and that further reviews are convened at intervals of not more than six months for as long as the child remains the

subject of a child protection plan. Where necessary, reviews should be brought forward to address changes in the child's circumstances.

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

**68.3** Ensure that the outcome of the review meeting is recorded, including whether the child should cease to be the subject of a child protection plan, and any changes to the child protection plan (Department of Health, 2002c).

**68.4** Ensure that if a child ceases to be the subject of a child protection plan, as a minimum, all those agencies' representatives who were invited to attend the initial child protection conference that led to the child becoming the subject of a child protection plan are notified.

### **The named keyworker should...**

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

**69.2** Prepare a report for the child protection review conference.

**69.3** Where the child ceases to be the subject of a child protection plan, discuss with the parents and the child what services might be wanted and required. This discussion should be based upon the re-assessment of the child's needs within his or her family, since the child may still require additional support and services. Ceasing to be the subject of a child protection plan should never lead to the automatic withdrawal of help.

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

### **All practitioners should...**

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

**70.2** Attend the review meeting, where appropriate.

## When may a child cease to be the subject of a child protection plan?

**80** A child may cease to be the subject of a child protection plan:

- as a result of a child protection review meeting deciding that the child is no longer in need of safeguarding via a child protection plan;
- if the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move and ceasing to be the subject of a child protection plan may only take place after a decision by this conference;
- when the child has reached 18 years of age, has died or has permanently left the UK.

## What happens if a child dies or suffers serious injury or sexual abuse?

**81** If a child dies, and abuse or neglect is known or suspected to be a factor in that death, the LSCB will conduct a review into the involvement with the child and family of agencies and professionals to establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children, identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and as a consequence, improve inter-agency working and better safeguard and promote the welfare of children. Also, the LSCB should always consider whether a serious case review should be conducted where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated; or
- a child has been killed by a parent with a mental illness; or
- the case gives rise to concerns about inter-agency working to protect children from harm.



More information about the serious case review process can be found in *Working Together*, Chapter 8.

### **All agencies should...**

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

**82.2** Contribute to the process of agreeing the report.

### **All professionals should...**

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

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

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

### **Designated health professionals should...**

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

# Appendix 1

## Use of questionnaires and scales to evidence assessment and decision making



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

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

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

- result in a fuller picture of a family’s history and contribute to greater contextual understanding of the family’s current situation;

- help practitioners explore how particular recent life events have affected the carer and the family;
- in some situations, identify life events which family members have not reported earlier.

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

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

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

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

**8 The Adolescent Wellbeing Scale** (Self-rating Scale for Depression in Young People, Birlleson, 1980). It was originally validated for children aged between 7 and 16. It involves 18 questions each relating to different aspects of a child or adolescent's life, and how they

feel about these. As a result of the pilot the wording of some questions was altered in order to be more appropriate to adolescents. Although children as young as seven and eight have used it, older children's thoughts and beliefs about themselves are more stable. The scale is intended to enable practitioners to gain more insight and understanding into how an adolescent feels about their life.

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

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

## Relevant Questionnaires and scales

Bentovim A and Bingley Miller L (2001) *The Family Assessment of Family Competence, Strengths and Difficulties*.

Pavilion Publishing, Brighton.

Cox A and Walker S (2002) *The HOME Inventory – Home Observation and Measurement of the Environment*.

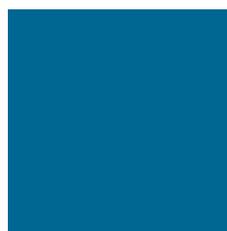
Pavilion Publishing, Brighton.

Department of Health, Cox A and Bentovim A (2000) *The Family Assessment Pack of Questionnaires and Scales*. The Stationery Office, London.

Website: [www.doh.gov.uk/qualityprotects/work\\_pro/project\\_3.htm](http://www.doh.gov.uk/qualityprotects/work_pro/project_3.htm)

# Appendix 2

## Legislative Framework



### Local Government Act 2000

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

### Children Act 2004

**2** Section 10 requires each local authority (LA) to make arrangements to promote co-operation between the authority, each of the authority’s relevant partners and such other persons or bodies working with children in the LA’s area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority’s area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for children’s trust arrangements.

**3** Section 11 requires a range of organisations to make arrangements for ensuring that their functions, and services provided on their behalf, are discharged with regard to the need to safeguard and promote the welfare of children.

**4** Section 12 enables the Secretary of State to require LAs to establish and operate databases relating to the s10 or s11 duties (above) or the s175 duty (below), or to establish and operate databases nationally. This section limits the information that may be included in those databases, and sets out which organisations can be required to, and which can be enabled to, disclose information to be included in the databases.

**5** Section 13 requires each children’s services authority to establish a LSCB. It also requires a range of organisations to take part in LSCBs. Sections 13–16 set out the

framework for LSCBs, and the LSCB Regulations set out the requirements in more detail, in particular on LSCB functions.

## Education Act 2002

**6** Section 175 puts a duty on local education authorities, maintained (state) schools and further education institutions, including sixth-form colleges, to exercise their functions with a view to safeguarding and promoting the welfare of children – children who are pupils, and students under 18 years of age in the case of schools and colleges.

**7** The same duty is put on local education authorities, including academies, by Regulations made under s157 of that Act.

## The Children Act 1989

**8** The Children Act 1989 places a duty on Local Authorities to promote and safeguard the welfare of children in need in their area.

*It shall be the general duty of every local authority –*

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

### **Children Act 1989 s17(1)**

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

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

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

*The persons are –*

*(a) any local authority;*

*(b) any local education authority;*

*(c) any local housing authority;*

*(d) any health authority, special health authority, Primary Care Trust, National Health Service Trust or NHS Foundation Trust; and*

*(e) any person authorised by the Secretary of State for the purpose of this section.*

**Children Act 1989 s27**

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

*Section 47 places a duty on –*

*(a) any local authority;*

*(b) any local education authority;*

*(c) any housing authority;*

*(d) any health authority, special health authority, Primary Care Trust, National Health Service Trust or NHS Foundation Trust; and*

*(e) any person authorised by the Secretary of State to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.*

Section 47 also sets out duties for the LA itself, around making enquiries in certain circumstances to decide whether they should take any action to safeguard or promote the welfare of a child.

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

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

*Every local authority –*

*(a) Shall facilitate the provision by others (including in particular voluntary organisations) of services which the authority have power to provide by virtue of this section, or section 18, 20, 23, 23B to 23D or 24A or 24B; and*

*(b) May make such arrangements as they see fit for any person to act on their behalf in the provision of any such service.*

**Children Act 1989 s17(5)**

**14** Section 53 of the Children Act 2004 amends both s17 and s47 of the Children Act 1989, to require in each case that before determining what services to provide or what action to take, the LA shall, so far as is reasonably practicable and consistent with the child's welfare:

- ascertain the child's wishes and feelings regarding the provision of those services or the action to be taken
- give due consideration (with regard to the child's age and understanding) to such wishes and feelings of the child as they have been able to ascertain.

## **Emergency protection powers**

**15** There are a range of powers available to local authorities and their statutory partners (i.e. NSPCC and the police) to take emergency action to safeguard children:

## Emergency protection orders

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

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

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

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

## Exclusion requirement

The Court may include an exclusion requirement in an emergency protection order or an interim care order (s38A and s44A of the Children Act 1989). This allows a perpetrator to be removed from the home instead of having to remove the child. The Court must be satisfied that:

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

## Police protection powers

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

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

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

## Homelessness Act 2002

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

## Recording

**17** The exemplars (Department of Health, 2002b and 2002c) produced to support the implementation of the Integrated Children's System contain the information requirements for children's social care, together with others when recording information about children in need and their families. The appropriate record to use at the different stages of working with children and families is referenced throughout this practice guidance.

# Appendix 3

## Information sharing



This appendix reproduces the guidance set out in the *Information sharing: Practitioners' guide* (HM Government, 2006)

This guidance is for everyone who works with children and young people, whether they are employed or volunteers, and working in the public, private or voluntary sectors. It is for staff working in health; education; early years and childcare; social care; youth offending; police; advisory and support services, and leisure. It is also for practitioners who work in services provided for adults, for example mental health services and drug and alcohol services, as many of the adults accessing those services may have parenting or caring responsibilities.

This document:

- summarises, in one page, six key points for practitioners to remember on information sharing in respect of children and young people (**Section 2**, page 55);
- sets out core guidance for practitioners on information sharing (**Section 3**, page 56);
- sets out further information to inform practitioners' decisions on information sharing (**Section 4**, page 61);
- includes a glossary of terms (page 69).

Available at [www.ecm.gov.uk/deliveringservices/informationsharing](http://www.ecm.gov.uk/deliveringservices/informationsharing)

### 1 Introduction

**1.1** The aim of the cross-Government guidance *Information sharing: Practitioners' guide* (2006c) is to improve practice by giving practitioners across children's services clearer guidance on when and how they can share information legally and professionally. It is reproduced in this publication for ease of access and to support practitioners in their work to safeguard and promote the welfare of children.

**1.2** Sharing information is vital for early intervention to ensure that children and young people with additional needs get the services they require. It is also essential to protect children and young people from suffering harm from abuse or neglect and to prevent them from offending.

**1.3** Improving information sharing practice is therefore a cornerstone of the Government's *Every Child Matters* strategy to improve outcomes for children. This guidance complements and supports wider policies to improve information sharing across children's services. See the website [www.ecm.gov.uk](http://www.ecm.gov.uk) for further information.

**1.4** It is important that practitioners understand when, why and how they should share information so that they can do so confidently and appropriately as part of their day-to-day practice. This document seeks to give practitioners clear practical guidance, drawing on experience and on the consultation that was carried out.

## **2 Six key points on information sharing**

- You should explain to children, young people and families at the outset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. The exception to this is where to do so would put that child, young person or others at increased risk of significant harm or an adult at risk of serious harm, or if it would undermine the prevention, detection or prosecution of a serious crime (see glossary for definition) including where seeking consent might lead to interference with any potential investigation.
- You must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration.
- You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information, if in your judgment on the facts of the case, there is sufficient need in the public interest to override that lack of consent.
- You should seek advice where you are in doubt, especially where your doubt relates to a concern about possible significant harm to a child or serious harm to others.
- You should ensure that the information you share is accurate and up-to-date, necessary for the purpose for which you are sharing it, shared only with those people who need to see it, and shared securely.

- You should always record the reasons for your decision – whether it is to share information or not.

### 3 Core guidance on sharing information

#### Why information sharing is important

**3.1** Sharing information is essential to enable early intervention to help children, young people and families who need additional services, to achieve positive outcomes, thus reducing inequalities between disadvantaged children and others. These services could include additional help with learning, specialist health services, help and support to move away from criminal or anti-social behaviour, or support for parents in developing parenting skills. As local areas move towards integrated children's services, professional and confident sharing of information is becoming more important to realising the potential of these new arrangements to deliver benefits for children, young people and families.

**3.2** Information sharing is also vital to safeguarding and promoting the welfare of children and young people. A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect.

**3.3** We know that practitioners recognise the importance of information sharing and that there is much good practice. But practitioners also tell us that in some situations they feel constrained from sharing information by their uncertainty about when they can do so lawfully. This guidance aims to provide clarity on that issue. It is important that practitioners:

- are supported by their employers in working through these issues;
- understand what information is and is not confidential, and the need in some circumstances to make a judgement about whether confidential information can be shared, in the public interest, without consent;
- understand and apply good practice in sharing information at an early stage as part of preventative work;
- are clear that information can normally be shared where you judge that a child or young person is at risk of significant harm or that an adult is at risk of serious harm.

The rest of this section covers these matters.

## How practitioners should be supported by their employers

**3.4** To give practitioners confidence to apply the guidance in practice, it is important that they have:

- a systematic approach within their agency to explaining to children, young people and families when they first access the service how and why information may be shared, which will build the confidence of all involved;
- clear systems, standards and protocols for sharing information. These may derive from their agency's policies, any local protocols in place, or from their professional code of conduct;
- access to training where they can discuss issues which concern them and explore case examples with other practitioners;
- a source of advice and support on information sharing issues.

**3.5** The statutory guidance on section 11 of the Children Act 2004 states that in order to safeguard and promote children's welfare, the agencies covered by section 11 should make arrangements to ensure that:

- a. all staff in contact with children and young people understand what to do and the most effective ways of sharing information if they believe that a child and family may require particular services in order to achieve positive outcomes;
- b. all staff in contact with children and young people understand what to do and when to share information if they believe that a child may be a child in need, including those children suffering or at risk of suffering harm;
- c. appropriate agency-specific guidance is produced to complement guidance issued by central Government, and such guidance and appropriate training is made available to new staff as part of their induction and ongoing training;
- d. guidance and training specifically covers the sharing of information between professions, organisations and agencies, as well as within them, and arrangements for training take into account the value of multi-agency as well as single agency training;
- e. managers in children's services are fully conversant with the legal framework and good practice guidance issued for practitioners working with children and young people.

The statutory guidance on section 10 of the Children Act 2004 makes it clear that effective information sharing supports the duty to co-operate to improve the wellbeing of children.

## Confidentiality

**3.6** In deciding whether there is a need to share information you need to consider your legal obligations including:

- a) whether the information is confidential; and
- b) if it is confidential, whether there is a public interest sufficient to justify sharing.

**3.7** Not all information is confidential. Confidential information is information of some sensitivity, which is not already lawfully in the public domain or readily available from another public source, and which has been shared in a relationship where the person giving the information understood that it would not be shared with others. For example, a teacher may know that one of her pupils has a parent who misuses drugs. That is information of some sensitivity, but may not be confidential if it is widely known or it has been shared with the teacher in circumstances where the person understood it would be shared with others. If however it is shared with the teacher by the pupil in a counselling session, for example, it would be confidential.

**3.8** Confidence is only breached where the sharing of **confidential** information is not authorised by the person who provided it or to whom it relates. If the information was provided on the understanding that it would be shared with a limited range of people or for limited purposes, then sharing in accordance with that understanding will not be a breach of confidence. Similarly, there will not be breach of confidence where there is explicit consent to the sharing.

**3.9** Even where sharing of confidential information is not authorised, you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option, if appropriate. Where consent cannot be obtained to the sharing of the information or is refused or where seeking it is likely to undermine the prevention, detection or prosecution of a crime, the question of whether there is a sufficient public interest must be judged by the practitioner on the facts of each case. Therefore, where you have a concern about a child or young person, you should not regard refusal of consent as necessarily precluding the sharing of confidential information.

**3.10** A public interest can arise in a wide range of circumstances, for example, to protect children or other people from harm, to promote the welfare of children or to prevent crime and disorder. There are also public interests, which in some circumstances may weigh against sharing, including the public interest in maintaining public confidence in the confidentiality of certain services. The key factor in deciding whether or not to share confidential information is proportionality, i.e. whether the proposed sharing is a proportionate response to the need to protect the public interest in question. In making

the decision you must weigh up what might happen if the information is shared against what might happen if it is not, and make a decision based on a reasonable judgment.

**3.11** It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. Practitioners must make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child, or serious harm to adults, the public interest test will almost certainly be satisfied. However there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.

**3.12** It is possible however to identify some circumstances in which sharing confidential information without consent will **normally** be justified in the public interest. These are:

- **when there is evidence** that the child is suffering or is at risk of suffering significant harm; or
- **where there is reasonable cause to believe** that a child may be suffering or at risk of significant harm; or
- **to prevent significant harm** arising to children and young people or *serious harm* to adults, including through the prevention, detection and prosecution of serious crime.

For the purpose of this guidance, serious crime means any crime which causes or is likely to cause significant harm to a child or young person or serious harm to an adult.

### **Sharing information as part of preventative services**

**3.13** There is an increasing emphasis on integrated working across children's services so that support for children, young people and families is provided in response to their needs. The aim is to deliver more effective intervention at an earlier stage to prevent problems escalating and to increase the chances of a child or young person achieving positive outcomes. For example, in some service areas there is increased use of multi-agency teams, for example in children's centres to support child health development; and through youth inclusion and support panels (YISPs) to support young people to help them move away from involvement in crime and disorder.

**3.14** Whether the integrated working is across existing services or through multi-agency teams, success depends upon effective partnership working between universal services (such as education and primary health care) and targeted and specialist services for those children, young people and families at risk of poor outcomes. Preventative services working in this way will be more effective in identifying concerns about significant harm, for example as a result of abuse or neglect. However, in most situations children, young people

and family members will require additional services in relation to education, health, behaviour, parenting, or family support, rather than intervention to protect the child or young person from harm or to prevent or detect serious crime.

**3.15** Effective preventative services of this type will usually require active processes for identifying children and young people at risk of poor outcomes, and passing information to those delivering targeted support. Practitioners sometimes express concern about how this can be done lawfully.

**3.16** Seeking consent should be the first option. Practitioners in universal, targeted and specialist services, including multi-agency services, should proactively inform children, young people and families, **when they first engage with the service**, about their service's policy on how information will be shared, and seek their consent. The approach to sharing information should be explained openly and honestly. Where this is done, young people and families will be aware how their information may be shared, and experience shows that most will give consent.

**3.17** Information which is not confidential may generally be shared where that is necessary for the legitimate purposes of preventative work. Where information is confidential, however, and consent is refused, that should be respected, unless in the practitioner's professional judgment on the facts of the case, the public interest justifies the sharing of information. Paragraphs 3.6 to 3.12 above explain this and make it clear that there will be cases where practitioners are justified in sharing confidential information without consent in order to make decisions on whether to share further information or take action.

### **Sharing information where there are concerns about significant harm**

**3.18** It is critical that all practitioners working with children and young people are in no doubt that where they have reasonable cause to suspect that a child or young person **may be suffering or may be at risk of suffering significant harm**, they should always consider referring their concerns to children's social care. While, in general, you should seek to discuss any concerns with the family and, where possible, seek their agreement to making referrals to children's social care, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm or lead to interference with any potential investigation. The child's interests must be the overriding consideration in making any such decisions.**

**3.19** In some situations there may be a concern that a child or young person may be suffering or at risk of significant harm or of causing serious harm to others, but you may be unsure whether what has given rise to your concern constitutes 'a reasonable cause to believe'. In these situations, the concern must not be ignored. You should always talk to

someone to help you decide what to do – a lead person on child protection, a Caldicott Guardian or a discussion with a trusted colleague or another practitioner who knows the child. The decision, to share information or not, should be recorded.

**3.20 Significant harm to children and young people** can arise from a number of circumstances – it is not restricted to cases of deliberate abuse or gross neglect. For example a baby who is severely failing to thrive for no known reason could be suffering significant harm but equally could have an undiagnosed medical condition. If the parents refuse consent to further medical investigation or an assessment, then you may still be justified in sharing information for the purposes of helping ensure that the causes of the failure to thrive are correctly identified.

**3.21** Similarly, **serious harm to adults** is not restricted to cases of extreme physical violence. For example, the cumulative effect of repeated abuse or threatening behaviour or the theft of a car for joyriding may well constitute a risk of serious harm. Again, it may be justified to share information without consent for the purposes of identifying children or young people for whom preventative interventions in relation to such behaviour are appropriate.

## **4 Further information to inform decision-making**

**4.1** To inform your decision-making this section sets out further information illustrating the key principles underlying information sharing. This section explains these through eight key questions. The relationship between them is illustrated in the flowchart at the end of this section. They are:

1. Is there a legitimate purpose for you or your agency to share the information?
2. Does the information enable a person to be identified?
3. Is the information confidential?
4. If the information is confidential, do you have consent to share?
5. Is there a statutory duty or court order to share the information?
6. If consent is refused, or there are good reasons not to seek consent to share confidential information, is there a sufficient public interest to share information?
7. If the decision is to share, are you sharing the right information in the right way?
8. Have you properly recorded your decision?

## Is there a legitimate purpose for you or your agency to share information?

**4.2** If you are asked to or wish to share information about a child or young person, you need to have a good reason or legitimate purpose to share information. This will be relevant to whether the sharing is lawful in a number of ways.

**4.3** If you work for a statutory service such as education, social care, health or youth justice, or if you work in the private or voluntary sector and are contracted by one of the statutory agencies to provide services on their behalf, the sharing of information must be within the functions or powers of that statutory body. It is likely that this will be the case if you are sharing the information as a normal part of the job you do for that agency.

**4.4** Whether you work for a statutory service or within the private or voluntary sector, any sharing of information must comply with the law relating to confidentiality, data protection and human rights. Establishing a legitimate purpose for sharing information is an important part of meeting those requirements. There is more information about the legal framework for sharing information in the document *Sharing Information: Further Guidance on Legal Issues* available at [www.ecm.gov.uk/deliveringservices/informationsharing](http://www.ecm.gov.uk/deliveringservices/informationsharing).

**4.5** Different agencies may have different standards for sharing information. You will need to be guided by your agency's policies and procedures, any local information sharing protocols, and – where applicable – by your professional code.

## Does the information enable a person to be identified?

**4.6** In most cases the information covered by this guidance will be about a named child or young person. It may also identify others, such as a parent or carer. If the information is anonymised, it can lawfully be shared as long as the purpose is legitimate. If, however, the information does allow a person to be identified, it is subject to data protection law and you must be open about what information you might need to share and why and you must also take account of other relevant laws.

## Is the information confidential?

**4.7** Confidential information is explained in paragraph 3.7. This section provides further information.

**4.8** There are different types of confidential relationship. One is where a formal confidential relationship exists, as between a doctor and patient, social worker and client, or counsellor and client. In these relationships all information shared, whether or not directly relevant to the medical, social care or personal matter which is the main reason for the relationship, needs to be treated as confidential.

**4.9** Another is an informal confidential relationship that exists between, say, a teacher and a pupil. A pupil may tell a teacher a whole range of information some of which is not confidential, but may also ask the teacher to treat some specific information as confidential. Then, for the purposes of the confidential information only, the teacher and pupil will have a formal confidential relationship.

**4.10** Sometimes people may not specifically ask you to keep information confidential when they discuss their own problems or pass on information about others, but may assume that personal information will be treated as confidential. In these situations you should check whether the information is or is not confidential, the limits around confidentiality and under what circumstances information may or may not be shared with others.

**4.11** Public bodies that hold information of a private or sensitive nature about individuals for the purposes of carrying out their functions (for example children's social care) may also owe a duty of confidentiality, as people have provided information on the understanding that it will be used for those purposes. In some cases the body may have a statutory obligation to maintain confidentiality, for example in relation to the case files of looked after children.

### **Do you have consent to share?**

**4.12** Consent issues can be complex, and lack of clarity about them can sometimes lead practitioners to incorrect assumptions that no information can be shared. This section gives further information to help you understand and address the issues. It covers:

- what constitutes consent;
- whose consent should be sought;
- when not to seek consent.

#### *What constitutes consent*

**4.13** Consent must be 'informed' – this means that the person giving consent needs to understand why information needs to be shared, who will see their information, the purpose to which it will be put and the implications of sharing that information.

**4.14** Consent can be 'explicit' or 'implicit'. Obtaining explicit consent is good practice and it can be expressed either orally or in writing, although written consent is preferable since that reduces the scope for subsequent dispute. Implicit consent can also be valid in many circumstances. Consent can legitimately be implied if the context is such that information sharing is intrinsic to the activity, and especially if that has been explained at the outset, for

example when conducting a common assessment. A further example is where a GP refers a patient to a hospital specialist and the patient agrees to the referral; in this situation the GP can assume the patient has given implied consent to share information with the hospital specialist.

**4.15** The approach to securing consent should be transparent and respect the individual. For example, it is good practice to set out clearly your agency's policy on sharing information to children, young people and families, when they first access the service. Consent cannot be secured through coercion, or inferred from a lack of response to a request for consent. If there is a significant change in the use to which the information will be put to that which has previously been explained, or in the relationship between the agency and the individual, consent should be sought again. Individuals have the right to withdraw consent after they have given it, although in practice this is rarely exercised.

*Whose consent should be sought*

**4.16** You may also need to consider whose consent should be sought. Where there is a duty of confidence it is owed to a person who has provided the information on the understanding it is to be kept confidential and, in the case of medical or other records, the person to whom the information relates. A young person aged 16 or 17, or a child under 16 who has the capacity to understand and make their own decisions, may give (or refuse) consent to sharing.

**4.17** Children aged 12 or over may generally be expected to have sufficient understanding. Younger children may also have sufficient understanding. When assessing a child's understanding you should explain the issues to the child in a way that is suitable for their age, language and likely understanding. Where applicable, you should use their preferred mode of communication.

**4.18** The following criteria should be considered in assessing whether a particular child on a particular occasion has sufficient understanding to consent, or refuse consent, to sharing of information about them:

- Can the child understand the question being asked of them?
- Does the child have a reasonable understanding of:
  - what information might be shared?
  - the main reason or reasons for sharing the information?
  - the implications of sharing that information, and of not sharing it?

- Can the child or young person:
  - appreciate and consider the alternative courses of action open to them?
  - weigh up one aspect of the situation against another?
  - express a clear personal view on the matter, as distinct from repeating what someone else thinks they should do?
  - be reasonably consistent in their view on the matter, or are they constantly changing their mind?

**4.19** In most cases, where a child cannot consent or where you have judged that they are not competent to consent, a person with parental responsibility should be asked to consent on behalf of the child.

**4.20** Where parental consent is required, the consent of one such person is sufficient. In situations where family members are in conflict you will need to consider carefully whose consent should be sought. If the parents are separated, the consent of the resident parent would usually be sought. If you judge a child or young person to be competent to give consent, then their consent or refusal to consent is the one to consider even if a parent or carer disagrees.

**4.21** These issues can raise difficult dilemmas. You must always act in accordance with your professional code of practice and in the best interests of the child, even where that means overriding refusal to consent.

#### *When not to seek consent*

**4.22** There will be some circumstances where you should not seek consent, for example where to do so would:

- place a child or young person at increased risk of significant harm; or
- place an adult at risk of serious harm; or
- prejudice the prevention or detection of a serious crime; or
- lead to unjustified delay in making enquiries about allegations of significant harm.

#### **Is there a statutory duty or a court order to share information?**

**4.23** In some situations you are required by law to share information, for example, in the NHS where a person has a specific disease about which environmental health services must be notified. There will also be times when a court will make an order for certain information or case files to be brought before the court.

**4.24** These situations are relatively unusual and where they apply you will know or be told about them. In such situations you must share the information, even if it is confidential and consent has not been given. Wherever possible, you should inform the individual concerned that you are sharing the information, why, and with whom.

#### **Is there sufficient public interest to share information?**

**4.25** Eliciting the views of children, young people and parents is important and represents good practice. However, even if consent is refused, that does not automatically preclude you from sharing information about a child about whom you have a concern. Paragraphs 3.6-3.12 above explain this in more detail, including the public interest test, the need to consider the public interest in maintaining confidence in confidentiality and how a risk of significant harm to a child or serious harm to an adult increases the public interest in sharing. There will be cases where sharing limited information without consent is justified to enable practitioners to reach an informed decision about whether further information should be shared or action should be taken.

**4.26** In deciding whether the public interest justifies disclosing confidential information without consent, you should be able to seek advice from your line manager or a nominated individual whose role is to support you in these circumstances. If you are working in the NHS or a local authority the Caldicott Guardian may be helpful. Advice can also be sought from professional bodies, for example the General Medical Council or the Nursing and Midwifery Council.

**4.27** If the concern is about possible abuse or neglect, all organisations working with children and young people will have a named person who undertakes a lead role for child protection, so consulting this person may also be helpful.

**4.28** If you decide to share confidential information without consent, you should explain to the person that you intend to share the information and why, unless one of the points at 4.22 is met.

#### **If the decision is to share, are you sharing the proper information in the proper way?**

**4.29** If your decision is to share, you should share information in a proper way. This means:

- share the information which is necessary for the purpose for which it is being shared;
- share the information with the person or people who need to know;
- check that the information is accurate and up-to-date;
- share it in a secure way;

- establish with the recipient whether they intend to pass it on to other people, and ensure they understand the limits of any consent which has been given;
- inform the person to whom the information relates, and, if different, any other person who provided the information, if you have not already and it is safe to do so.

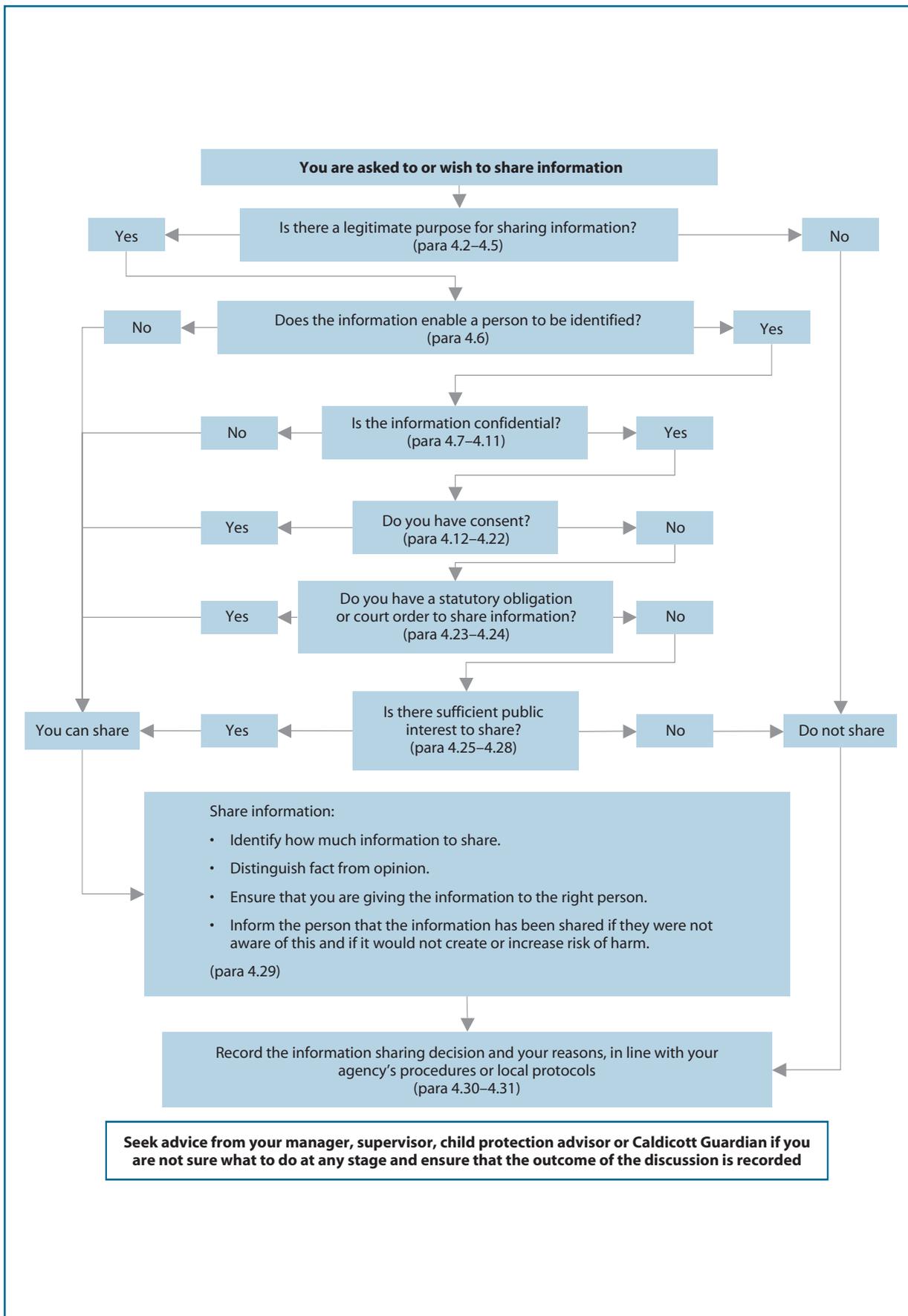
### **Have you properly recorded your decision?**

**4.30** You should record your decision and the reasons for it whether or not you decide to share information. If the decision is to share, you should record what information was shared and with whom.

**4.31** You should work within your agency's arrangements for recording information and within any local information sharing protocols in place. These arrangements and protocols must be in accordance with the Data Protection Act 1998 – the key provisions of which are summarised in *Sharing Information: Further Guidance on Legal Issues* available at [www.ecm.gov.uk/deliveringservices/informationsharing](http://www.ecm.gov.uk/deliveringservices/informationsharing).

**4.32** A glossary is included on pages 69–70.

## Flowchart of key principles for information sharing



## Glossary – Information Sharing: Practitioners’ Guide

**Anonymised** information is information from which a person cannot be identified by the recipient.

**Confidential** information should not normally be in the public domain or readily available from another source, it should have a degree of sensitivity and value and be subject to a duty of confidence.

**Consent** is agreement freely given to an action based on knowledge and understanding of what is involved and its likely consequences. All consent must be informed. The person to whom the information relates should understand why particular information needs to be shared, who will use it and how, and what might happen as a result of sharing or not sharing the information.

**Explicit consent** is consent given in orally or in writing

**Implied consent** is where the person has been informed about the information to be shared, the purpose for sharing and that they have the right to object and their agreement to sharing has been signalled by their behaviour rather than orally or in writing.

**Personal data** is information about any identified or identifiable living individual and includes their name, address and telephone number as well as any reports or records.

**Practitioner** is the generic term used in this guidance to cover everyone who works with children and young people.

**Proportionality** the key factor in deciding whether or not to share confidential information without consent is **proportionality** i.e. is the information you wish to, or are asked to, share a balanced response to the need to safeguard a child or another person, or to prevent or detect a serious crime?

**Public bodies** are any public service, for example a local authority, health services or schools.

**Public interest** is the interests of the community as a whole, or a group within the community or individuals.

**Public interest test** is the process a practitioner uses to decide whether to share confidential information without consent. It requires them to consider the competing public interests – for example, the public interest in protecting children, promoting their welfare or preventing crime and disorder and the public interest in maintaining public confidence in the confidentiality of public services, and to balance the risks of not sharing against the risk of sharing.

**Safeguarding and promoting welfare** is the process of protecting children from abuse or neglect, preventing impairment of their health and development and ensuring they are growing up in circumstances consistent with the provision of safe and effective care which is undertaken so as to enable children to have optimum life chances and enter adulthood successfully.

**Serious crime** for the purposes of this guidance means any crime which causes or is likely to cause significant harm to a child or young person or serious harm to an adult.

**Serious harm** for the purposes of this guidance can be either physical or mental trauma to an adult

**Significant harm** – there are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism, and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, for example a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the family's strengths and supports. *Working Together to Safeguard Children* has further information.

**Well-being** has a legal definition based on the five *Every Child Matters* outcomes; the achievement of these outcomes is in part dependent upon the effective work to safeguard and promote the **welfare** of children.

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