Area Child Protection Committees'

REGIONAL POLICY AND PROCEDURES

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April 2005

Acronyms

A+E	Accident and Emergency Department
ACPC	Area Child Protection Committee
ACSM	Area Children's Services Manager
AHP	Allied Health Professional
APSW	Assistant Principal Social Worker
ASORMC	Area Sex Offender Risk Management Committee
CARE Unit	Child Abuse and Rape Enquiry Unit (within Police Service of Northern Ireland)
CCMS	Council for Catholic Maintained Schools
Children Order	The Children (Northern Ireland) Order 1995
CT Scan	Computed Tomography Scan
DE	Department of Education
DHSSPS	Department of Health, Social Services and Public Safety Northern Ireland
DPP	Director of Public Prosecutions/Public Prosecution Service
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
ELB	Education and Library Board
ETI	Education and Training Inspectorate
FMO	Forensic Medical Officer
GMC	General Medical Council
GP	General Medical Practitioner
GUM	Genito-Urinary Medicine
HSS	Health & Social Services
Joint Protocol	The Protocol for Joint Investigation by Police Officers and Social Workers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2004)
MASRAM	Multi-Agency Sex Offender Risk Assessment and Management
NSPCC	National Society for the Prevention of Cruelty to Children
PACE	Police and Criminal Evidence (NI) Order 1989
PBNI	Probation Board for Northern Ireland
PECS	Pre-Employment Consultancy Service
PSNI	Police Service of Northern Ireland
RSHO	Risk of Sexual Harm Order
SSAFA	Soldiers, Sailors and Airmen's Families Association
TCPP	Trust Child Protection Panel

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FOREWORD

The first edition of the Regional Child Protection Policy & Procedures has been written to reflect the changes in thinking and in practice which are contained in 'Co-operating to Safeguard Children', (May 2003). 'Co-operating to Safeguard Children' replaces 'Co-operating to Protect Children' which was issued in November 1996 as Volume 6 of the Regulations and Guidance to The Children (NI) Order 1995. The Policy & Procedures also incorporate lessons learnt from the Victoria Climbié Inquiry Report (2003), the DHSSPS Multi-Professional Audit (2003), the Independent Review Report into the case of David and Samuel Briggs (2003) and the Bichard Inquiry (2004).

This Policy & Procedures acknowledges that child protection services must be part of a continuum of services available to children in need and their families. They also reflect the increasing recognition of the social context in which the protection of children takes place. The vulnerability of children with disabilities, children who sexually abuse others, bullying, violence at home, substance misuse, commercial sexual exploitation of children and the risks posed by developments in communications technology are recognised as having significant implications for the well-being and protection of children.

The Area Child Protection Committees' believe that children are best cared for by their family within their local community provided it is safe to do so. In the great majority of cases it will be up to parents to decide when to seek help and advice concerning their children's care and upbringing. Exceptionally, however, it will be necessary for statutory agencies to intervene in family life without invitation when it is necessary to safeguard a child from harm. On every occasion of such intervention the statutory agency must be able to show that the grounds for qualification to Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) apply. These Procedures detail the process that will be followed in such cases throughout the Region and the context in which the work is undertaken.

As well as detailing the key elements of the Child Protection Process, this document also aims to facilitate an understanding of the role of staff in the various agencies and provide helpful guidance on the recognition of child abuse and the legal framework by which children are protected.

Children are best protected from harm by high standards of professional practice in all agencies. This demands close co-operation between agencies and co-ordination of services across agencies. These Procedures provide the framework to facilitate the necessary high standards and to ensure that personnel in all agencies and the public are aware of the Policy & Procedures by which the safety of children is protected throughout the Region.

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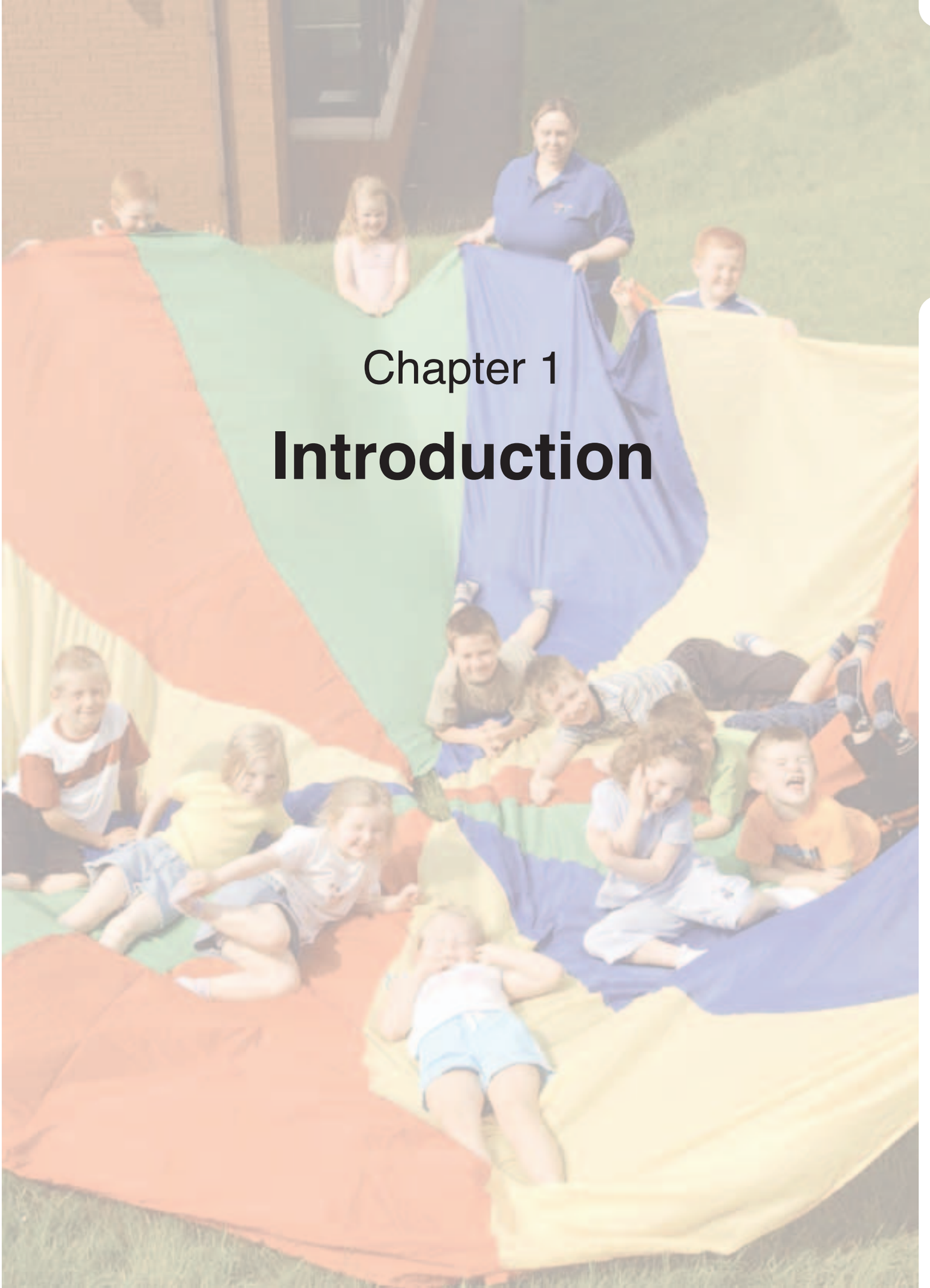

Chapter 1
Introduction

CHAPTER 1 INTRODUCTION

Policy Statement

1.1 All Agencies represented on the Area Child Protection Committee (ACPC) are committed to supporting children in their families and communities. Families will be supported in conjunction with universal services provided by Education, Health Services and Voluntary Organisations that have skills in assisting parents[1] and their children. In the majority of cases the parents will decide when to seek help and advice on their children's care and upbringing. Exceptionally, however, it may be necessary for Statutory Agencies to intervene in family[2] life when an assessment is required of the need to safeguard a child from the risk of significant harm. Children who are suffering or are at risk of suffering significant harm, either as the result of a deliberate act or through failure to act or provide proper care, need to be made safe from harm alongside meeting their other needs.

1.2 These Procedures detail the processes that must be followed in respect of children in need of protection. It does not cover other responses to children in need. It does reflect, however, a growing recognition that the Child Protection Process is closely integrated with family support services thus enabling a range of prevention, support and protection services to be offered and tailored to meet the specific assessed needs of children and families.

Vision

1.3 The vision of the ACPC is that children should be brought up in a safe environment that promotes their welfare and protects them from significant harm.

Principles

1.4 Working with children and families where child protection is a concern raises complex issues of values, rights and potentially conflicting interests. It is important, therefore, to be guided by a set of principles as well as by professional knowledge.

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[1] The term 'parent' includes those with parental responsibility and those who act as carers

[2] Family is used in respect of parents with parental responsibility, and those who act as carers of the the child who is the focus of professional concern as well as any other child in the household. In certain cases family may include other relative including grandparents, aunts and uncles, or siblings, depending upon the family circumstances.

1.5 Strategies, policies, procedures and services to safeguard children should be based on the principles contained in paragraph 1.13 of "Co-operating to Safeguard Children".

Human Rights

1.6 The Children (NI) Order 1995 (Children Order) and the United Nations Convention on the Rights of the Child (1989) state that provision of services and protection from abuse are basic rights and must be offered to all children regardless of race, culture, language, gender, disability and religion.

1.7 When taking action in any child protection investigation, consideration will have to be given to the human rights of the child and the family. Sometimes it may be necessary to infringe such rights, for both the parent and child, e.g. the right to a private and family life. When a child or family's rights are infringed, the reasons must be clearly recorded in the child's case files/records.

Equal Opportunities

1.8 The ACPC is committed to promoting equal opportunities and to working in a non-discriminatory manner. Section 75 of the Northern Ireland Act 1998 requires public agencies to have due regard to the need to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation
- men and women generally
- persons with a disability and persons without
- persons with dependants and persons without.

There is also a requirement to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group. In keeping with these legislative requirements these procedures have been screened from an equality of opportunity and human rights perspective.

Race, Ethnicity, Culture and Religious Upbringing

1.9 All children have the right to grow up safe from harm. Children from all cultures may be subject to abuse and neglect; cultural or other factors should not condone acts of omission or commission that place a child at risk of significant harm.

1.10 The baseline for assessing the risk of significant harm to a child should be the same irrespective of the child's ethnic origin. The assessment should consider the influence of differing racial and cultural beliefs on the values, attitudes and behaviour of the family. Evidenced based assessments of the child's needs and a family's strengths and weaknesses, will help to avoid any distorting effect of these cultural influences on professional judgement.

1.11 To achieve sensitive and inclusive practice staff should:

- consider cultural background and religious upbringing in order to assist in the understanding of the child and family circumstances
- be sensitive to racial and cultural variations within groups and between individuals
- take account of experiences of any discrimination in an individual's response to public services
- confirm the accuracy of the interpretation of information with the child and family.

1.12 Anxiety about being accused of racist or sectarian practice should not prevent necessary action being taken to safeguard a child.

1.13 It is important that communication should be in the family's primary language in order to gain a full understanding of the difficulties they may be facing. Interpreters from the Regional Interpreting Service should be used to assist communication with the family. It is not good practice to use children or relatives as interpreters. (See Appendix 3 for contact details).

Disability

1.14 Safeguards for children with disability should be the same as those for other children. Special input may be required if the child has severe or multiple disabilities. As in all child protection cases, a multi-disciplinary approach should be used and agreement should

be reached with regard to who is responsible for the Child Protection Investigation.

A Shared Responsibility

1.15 Effective child protection is firmly based on co-operation and commitment between staff and agencies and shared decision-making. The judgements that have to be made about risks to children are often difficult and involve the prediction about future actions or behaviours. The serious implications that decisions may have on the lives of children concerned and their parents often compound the gravity of the risks.

1.16 It must follow, therefore, that safeguarding children is characterised by joint working, shared decision-making and by a management overlay which ensures, in each case, that information is collected and analysed, that decisions are taken and that plans are always fully implemented. The systems for child protection are primarily to protect the interests of children considered to be at risk. Their needs must always come first.

1.17 Although the Health and Social Services Trust is the lead agency in relation to investigating child care concerns, other agencies have a responsibility to co-operate, own and implement decisions taken within the Child Protection Process.

Safety Issues for Professionals

1.18 All staff across the range of settings working with children and their families should be aware that families may be distressed by the issues leading to involvement with the Child Protection System. This may result in some parents acting in an aggressive or intimidatory manner towards professionals. Therefore staff need to be alert to the risks to their own personal safety and ensure that any potential risks are discussed with line managers and colleagues from other disciplines in order to minimise these. Staff should be familiar with their agency's policy and procedures on personal safety.

In taking account of the potential risks to staff in working with distressed or aggressive parents, staff and management must ensure that the actions necessary to safeguard a child, for example seeing a child, are not compromised.

Confidentiality

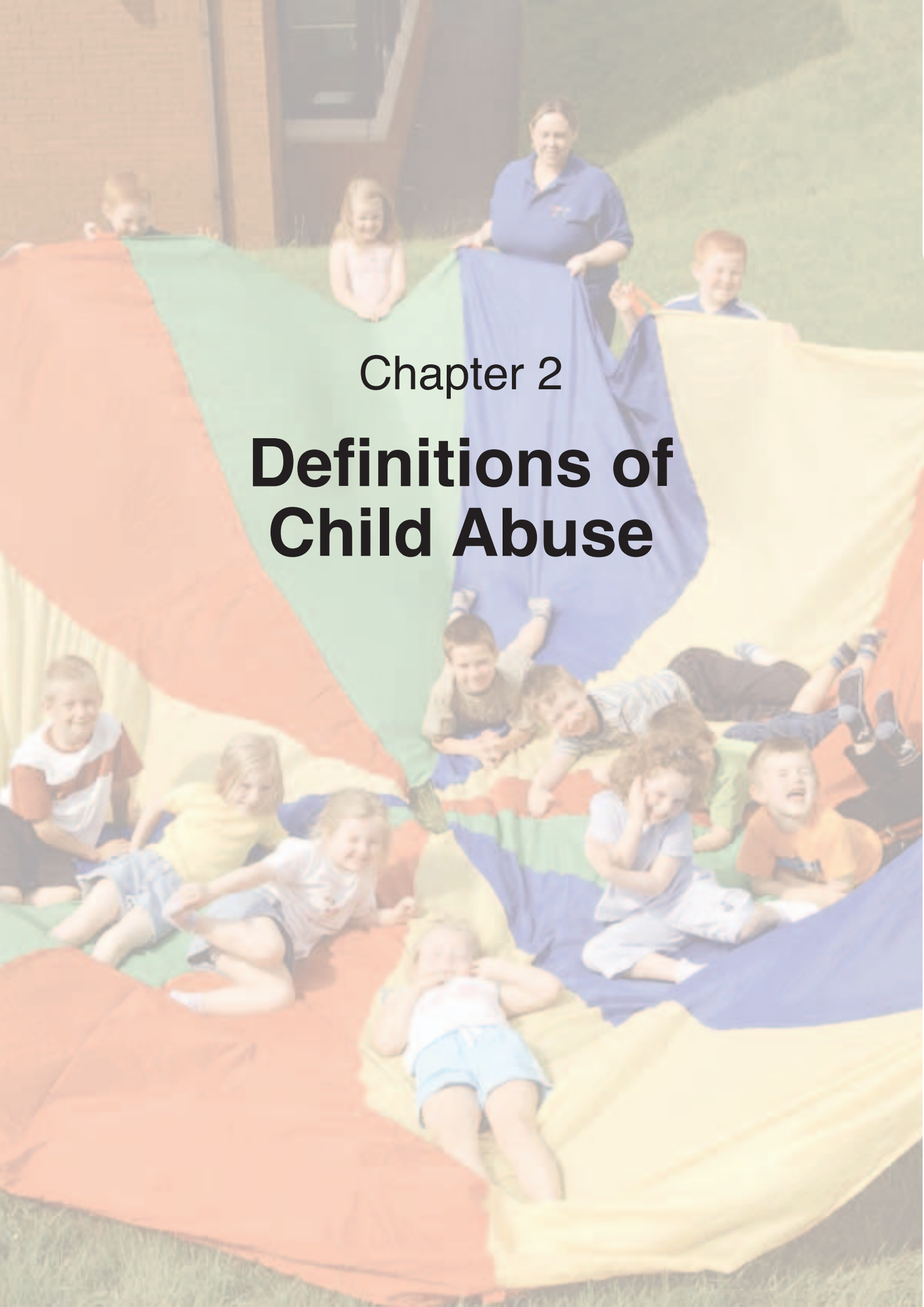
1.19 It is necessary to ensure that each agency's confidentiality policy is clearly understood by all involved. This includes those situations where information must be shared with others in the interests of a child's safety and the reasons why. It is equally important that each agency has a mutual understanding of each other's confidentiality policy.

1.20 Professionals must take cognisance of the central and recurring message in child abuse enquires that information relevant to the Child Protection Process must be shared with appropriate professionals and agencies in the interests of children.

1.21 The welfare of the child is paramount. Where there is reasonable cause to believe that a child is at risk of significant harm, the matter will be viewed as child protection and in these instances the parent should be informed of the concerns and the action required, and their agreement sought where possible **and if appropriate.** If agreement is not forthcoming, protection of the child will take precedence over confidentiality. Sharing information in such circumstances is not deemed a breach of professional conduct and is in keeping with these Child Protection Policies and Procedures. Please refer to Chapter 11 of these procedures for further guidance and section 7.3 and 8.6 of Co-operating to Safeguard Children.

Relevant Legislations/Publications

1.22 These Policy and Procedures cannot be exhaustive and cover every eventuality. Professional judgement on individual cases will always be required. Managers and practitioners should ensure that they are familiar with and have access to a number of other publications, such as those listed in Appendix 1.



Chapter 2

Definitions of Child Abuse

CHAPTER 2 DEFINITIONS OF CHILD ABUSE

2.1 The definitions of a child, abuse and significant harm are contained in Chapter 2 of 'Co-operating to Safeguard Children'. They are as follows:

Definition of a Child

2.2 For the purpose of these Procedures, a child is a person under the age of 18 years as defined in the Children Order.

Definition of Abuse

2.3 Child abuse occurs when a child is neglected, harmed or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely, by a stranger. There are different types of abuse and a child may suffer more than one of them. The procedures outlined in this document are intended to safeguard children who are at risk of significant harm because of abuse or neglect by a parent, carer or other with a duty of care towards the child.

Types of Abuse

Physical Abuse is the deliberate physical injury to a child, or the wilful or neglectful failure to prevent physical injury or suffering. This may include hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, confinement to a room or cot, or inappropriately giving drugs to control behaviour.

Emotional Abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that he is worthless or unloved, inadequate, or valued only insofar as he meets the needs of another person. It may involve causing a child frequently to feel frightened or in danger, or the exploitation or corruption of a child. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Domestic violence, adult mental health problems and parental substance misuse may expose a child to emotional abuse.

Sexual Abuse involves forcing or enticing a child to take part in sexual activities. The activities may involve physical contact,

including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.[3]

Neglect is the persistent failure to meet a child's physical, emotional and/or psychological needs, likely to result in significant harm. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, failing to ensure access to appropriate medical care or treatment, lack of stimulation or lack of supervision. It may also include non-organic failure to thrive (faltering growth).

2.4 A child may suffer or be at risk of suffering from one or more types of abuse and abuse may take place on a single occasion or may occur repeatedly over time.

2.5 **Young Person whose Behaviour places him[4] at Risk of Significant Harm** – a child whose own behaviours, such as alcohol consumption or consumption of illegal drugs, whilst placing the child at risk of significant harm, may not necessarily constitute abuse as defined for the purposes of these Procedures. If the child has achieved sufficient understanding and intelligence to be capable of making up his own mind then the decision to initiate child protection action in such cases is a matter for professional judgement and each case should be considered individually. The criminal aspects of the case will be dealt with by the Police.

[3] Sexual activity involving a child who is capable of giving informed consent on the matter, **while illegal**, may not necessarily constitute sexual abuse as defined for the purpose of this guide. One example which would fall into this category is a sexual relationship between a 16 year old girl and her 18 year old boyfriend. The decision to initiate child protection action in such cases is a mater for professional judgement and each case should be considered individually. The criminal aspects of the case will, of course be dealt with by the Police.

[4] Throughout these Procedures, the terms he, him etc should be construed as also meaning she, her etc. Throughout these Procedures, the terms parent, carer etc should be construed as also meaning parents, carers etc.

Guidance on Significant Harm

2.6 Whilst there are no absolute criteria for judging what constitutes significant harm, there are a number of stages in the Child Protection Process where professionals have to make judgements in relation to it. These are:

1. following initial assessment, when deciding to make further enquiries under Article 66 of the Children Order
2. following Article 66 enquiries, when deciding whether or not to convene an Initial Child Protection Case Conference
3. in the Child Protection Case Conference, when deciding whether or not to place a child's name on the Child Protection Register
4. for Social Services and the Police, in deciding whether to apply for a variety of Orders under the Children Order.

Harm

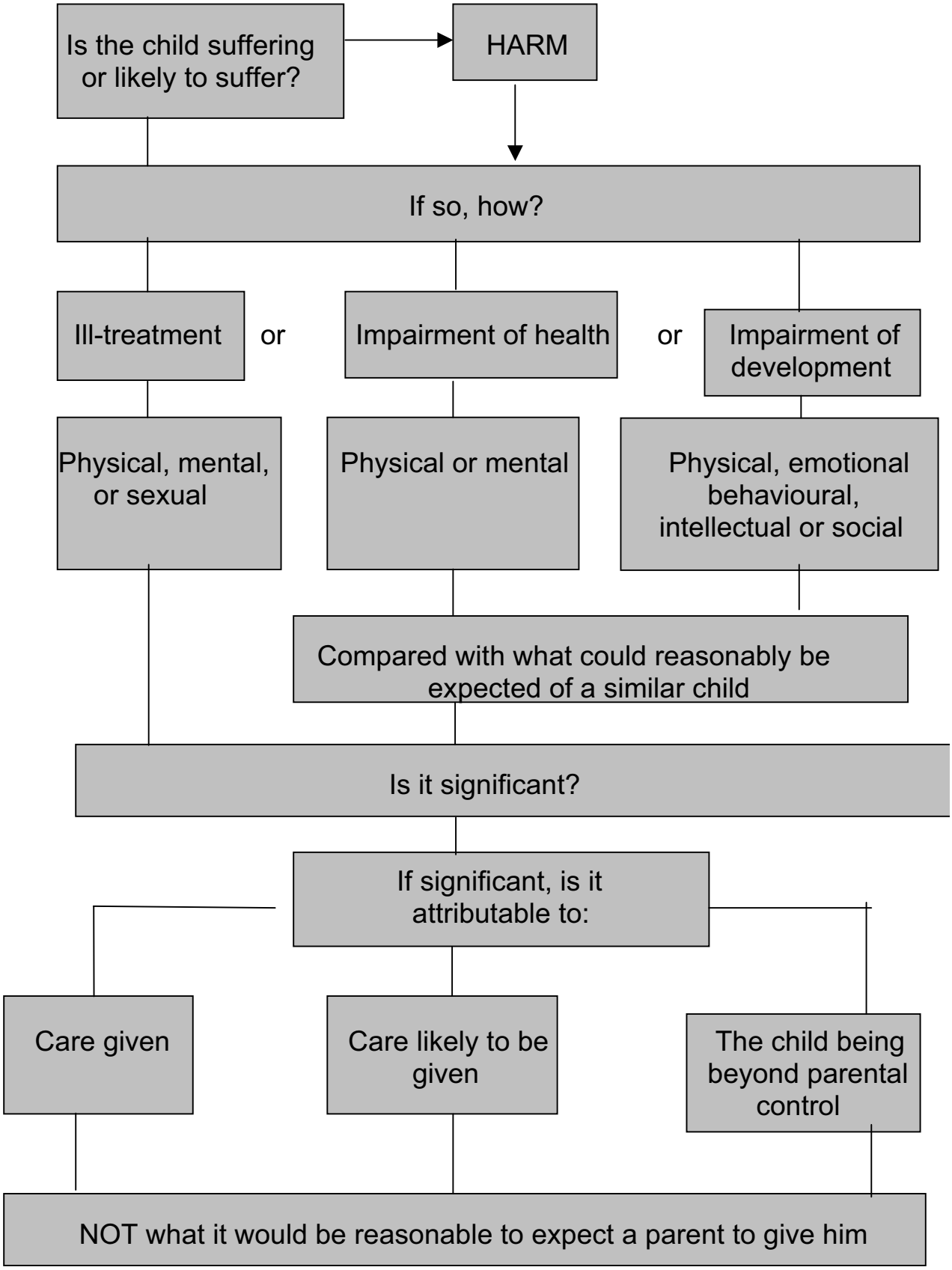
2.7 Harm is defined in the Children Order as "ill-treatment or the impairment of health or development". The Children Order definition of ill-treatment includes:

- sexual abuse and forms of ill-treatment which are not physical
- health means physical or mental health
- development means physical, intellectual, emotional, social or behavioural development.

2.8 Whether the harm is significant is determined by the health and development of the child as compared with that which could reasonably be expected of a similar child.

2.9 The following diagram is helpful in determining what may constitute significant harm. (From Adcock and White (Eds) (1998)).

Significant Harm Criteria



2.10 It is important to bear in mind that the health or development of a child subject to ill-treatment may be impaired in a number of different ways. For example:

- physical abuse can lead directly to physical injury, disability and neurological damage but also has been linked to aggressive behaviour in children, emotional, behavioural and educational problems
- sexual abuse can cause physical injury and can also lead to a variety of disturbances in behaviour and emotional health
- emotional abuse can impact on a child's mental health, behaviour and self esteem
- neglect can cause impairment of physical growth, intellectual development and social functioning.

Significant Harm

2.11 The significance of harm will be a matter for assessment and judgement in relation to each individual child. There are no absolute criteria but the following should be borne in mind:

- the seriousness of the alleged harm, for example prior convictions of a parent/carer for offences against a child or young person or prior allegations of significant harm although a criminal conviction has not been secured
- the type and site of any physical injury
- the age of the child
- the duration and frequency of abuse and neglect. Sometimes a single traumatic event may constitute significant harm, but more often it is an accumulation of events, both acute and long-standing, which cause the harm
- the context in which the harm takes place. For every child, there may be factors which aggravate the harm caused, such as living in a family characterised by low warmth/high criticism
- the needs of the individual child. For example, a severely disabled child may need a much greater level of supervision than a non-disabled child of the same age, so that a 'home alone' scenario would have greater significance.
  In determining whether or not harm is significant, the Children

Order requires comparison of the individual child's health or development with that which could reasonably be expected of a similar child, i.e. a child with a similar level of needs, not a child of similar parents, or living in a similar setting

- the presence of factors such as premeditation, threats and coercion, sadism and bizarre or unusual elements in child sexual abuse have all been associated with more severe effects on the child
- the family's willingness to address the issues presented during the assessment.

2.12 In assessing and establishing significant harm, it is therefore necessary to consider:

- the child's development within the context of his family and wider social and cultural environment
- the family context
- the adequacy of parental care
- the impact on the child's health and development
- the nature of harm, in terms of ill-treatment or failure to provide adequate care
- any special needs, such as a medical condition, communication difficulty or disability that may affect the child's development and care within the family.

2.13 It is important always to take account of the child's reactions, and his perceptions, according to the child's age and understanding.

Likelihood

2.14 Although not defined in the legislation, 'likely' clearly means more than merely possible but less than certain. As a working definition, likely can be taken to mean 'more likely than not'.

Compulsory Intervention

2.15 In a small number of cases, where significant harm has been established, Social Services may need to consider using the provisions of the Children Order to apply for one or more of a number of Orders. Thoburn and Bailey (1996) have suggested the

following list of questions to be asked where such action is being considered:

- Is the child actually suffering significant harm?
- How likely is it that the child will suffer significant harm in the short term and long term future?
- Is there a danger that the child will be sexually exploited by a carer?
- Is there a parent or carer who is able to make a concerted effort to protect the child from significant harm?
- Is this carer willing to make a concerted effort to protect the child from significant harm?
- Does this carer have some positive feeling towards the child?
- Is the parent/carer willing to work with agencies to secure the child's protection from future harm?
- Is the older child willing to work with agencies to keep him/herself safe from future harm?
- Are the parent and child able (e.g. not prevented by a serious mental illness or immaturity of personality leading to impulsive behaviour) to work with agencies to protect the child from significant harm?
- Is there any evidence that the steps which would be taken and the methods used, if compulsory action were taken, are likely be to effective?
- Is there anything to suggest that if compulsory action is taken the child is more likely to be helped than harmed?
- Is the outcome of compulsory intervention better in the long-term for the child and family?

NB: It is the pattern and combination of the answers to these questions that is important, not the answer to any one question on its own.

Recognition of Child Abuse

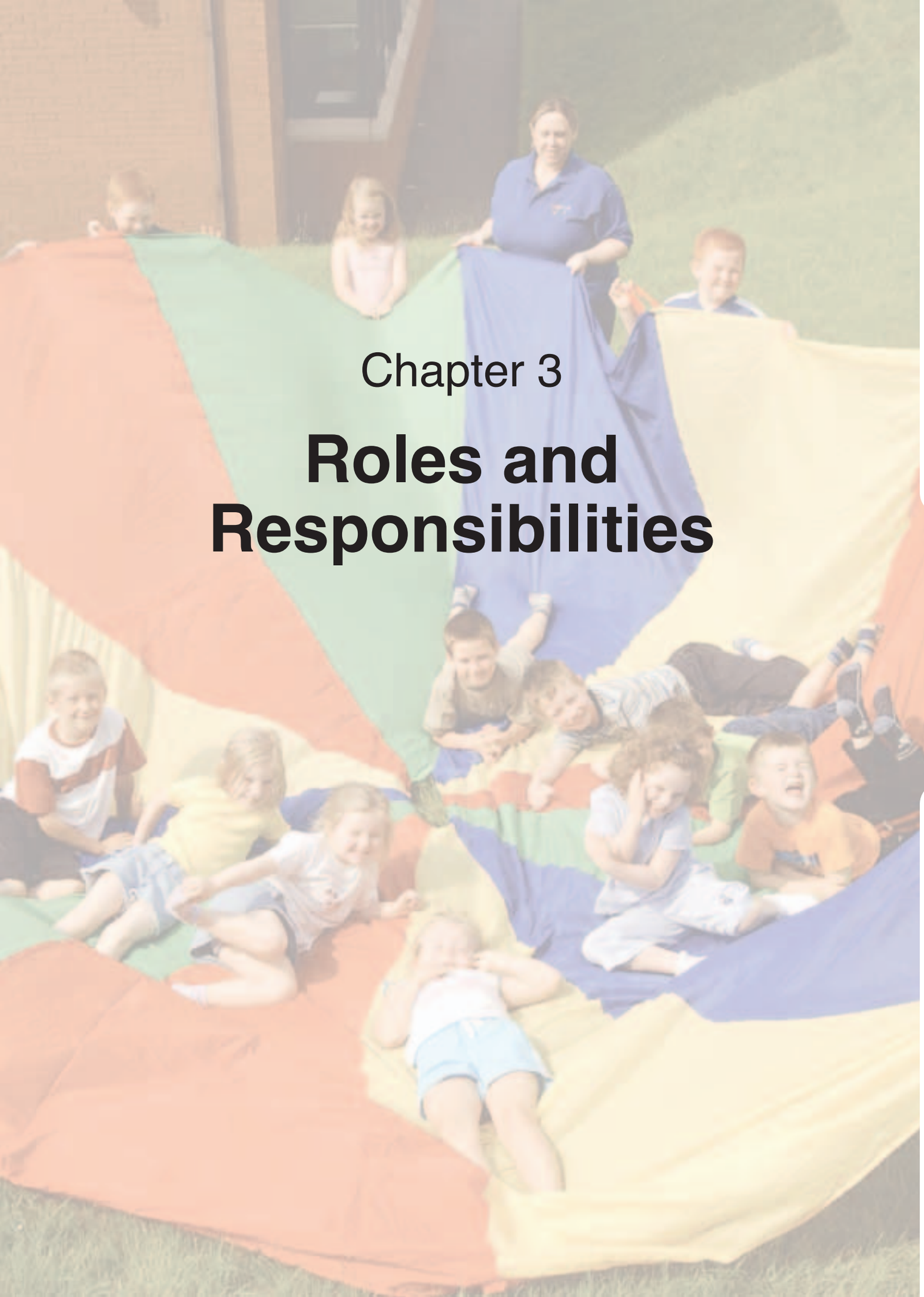
2.16 The recognition and identification of child abuse can be difficult and usually requires information from individual sources including detailed social and medical assessments. The final decision will be

made at a Child Protection Case Conference, which will also decide if a child's name should be placed on the Child Protection Register and under what category of abuse.

2.17 It is the responsibility of professionals, whether from statutory agencies or otherwise, to report concerns, not to decide whether it is, or is not, child abuse. No one individual can make the decision that a child has been, or will be harmed.

2.18 Professional concerns about "false allegations" need to be set aside as the need to safeguard the child must be paramount.

2.19 All professionals working with children and families need to be aware of the indicators of child abuse. Appendix 2 provides a list of signs and symptoms of abuse which may be useful for reference purposes.



Chapter 3

Roles and Responsibilities

CHAPTER 3 ROLES AND RESPONSIBILITIES

Introduction

3.1 This chapter describes the roles and responsibilities of the main agencies and professionals involved in child protection. Awareness and appreciation of each other's roles is essential for effective co-operation. Joint working should extend across the planning, management, provision and delivery of services.

3.2 At times all those involved in children's work need access to specialist advice. No one agency or discipline can undertake the complex task of protecting children on its own. Consultation and advice about child protection and the wide range of issues that affect children and their families is available through Children's Services within each Health and Social Services Trust.

Health and Social Services Boards

3.3 Health and Social Services Boards (HSS Boards), in consultation with other agencies, have a duty to assess the requirement for, and plan services for, children in need as a whole (Children's Services Plans). Boards also have the lead responsibility for the establishment and effective functioning of Area Child Protection Committees within each HSS Board which are multi-agency committees that act as a focal point for local co-operation specifically to safeguard children considered to be at risk of significant harm.

Area Child Protection Committee

3.4 The role of the ACPC is to develop a strategic approach to child protection within the overall Children's Services Planning process. Its specific responsibilities are set out in Chapter 4 of 'Co-operating to Safeguard Children'. Included within these responsibilities is the need to monitor and evaluate, on a regular and continuing basis, how well services work together to protect children and to ensure that a specific report on outcomes is conveyed to the Board, Trusts, constituent agencies of ACPC and professional groups.

Health and Social Services Trusts

3.5 Health and Social Services Trusts (HSS Trusts) have a duty and responsibility to provide a wide range of services for individuals and

for families. They have regulatory functions in relation to services provided by the voluntary and private sector and they may also work collaboratively with these bodies.

3.6 HSS Trusts have a statutory duty to investigate where they have reasonable cause to suspect that a child is suffering, or is likely, to suffer significant harm or is subject to an Emergency Protection Order or Police Protection, or at the direction of a Court under Article 56 of the Children Order. HSS Trusts can ask others to help with investigations in particular by providing relevant information and advice. Others obliged to help, when a Trust makes a reasonable request for assistance are included under Article 66 (11) of the Children Order.

Directors of Health & Social Services Boards and Trusts

3.7 On appointment a Director of Health and Social Services, in either a Board or Trust, whether in an executive or non-executive capacity, acquires important responsibilities for the health and well-being of children in his[5] area. The respective duties and legal responsibilities for HSS Boards and Trusts for children are mainly set out in the Children Order and its associated guidance and regulations. All Directors have a duty to take an active interest in ensuring that the management and other arrangements in place within HSS Boards and Trusts are appropriate to the delivery of high quality and well-managed services for children (See HSS Circular 3/02 for details relating to Roles and Responsibilities).

3.8 A Director sets the strategic direction of an HSS Board's or Trust's services and determines policy and priorities within the overall objectives set by the Department. In order to do so, he needs to make sure he has up-to-date and relevant information on which to base his decisions. He needs to know about the services and resources for children in his area. The type and extent of information which should be available to Directors is set out in HSS Circular CC3/02.

[5] Throughout this document, the terms he, him etc should be construed as also meaning she, her etc

Board Designated Doctor for Child Protection and Trust Named Paediatrician for Child Protection

3.9 The responsibilities of the Board's designated Doctor and Trust Named Paediatrician for Child Protection are outlined in paragraphs 3.17 – 3.19 of 'Co-operating to Safeguard Children'.

Both designated and named doctors (who may in some cases be the same person) will provide specialised paediatric advice in complex cases of child abuse to other colleagues and disciplines and will act as a reference point for other agencies. Where Hospital (or Community) Trusts do not have medical staff with the expertise and training related to, in particular, child sexual abuse, they should nominate, by agreement, a doctor from another Trust who will provide the necessary input and expertise.

Board Designated Nurse for Child Protection and Trust Named Nurse for Child Protection

3.10 Each HSS Board should nominate a Designated Nurse for Child Protection and each HSS Trust, including hospital Trusts, should appoint a Named Nurse for Child Protection. His respective responsibilities are outlined later in this chapter.

Social Workers in Family and Child Care Teams

3.11 The Child Protection work of Health and Social Services Trusts should be considered in the wider context of their work to assist families to care for their children and fulfil their parental responsibilities through the provision of family support services. This provision can include advice, guidance and counselling, day-care facilities, residential accommodation and foster placements etc. Social Workers engaged in child protection work may also be involved in a wide range of other child care work. They are aware of the wider child care facilities provided by the HSS Trusts and other agencies and can draw on these in order to provide support and treatment services for children in need.

3.12 All referrals/concerns received by Family and Child Care Teams about children where there is a suspicion of significant harm/abuse will be investigated by a Social Worker or the Police Service of Northern Ireland (PSNI) or jointly by PSNI and a Social Worker. It should be noted that although the primary purpose for police investigation relates to alleged criminal offences, the functions of police and social services in cases of child protection are complimentary. Consideration should be given to the 'Protocol for Joint Investigation by Police Officers and Social Workers of Alleged and Suspected Cases of Child Abuse – Northern Ireland' (Joint Protocol).

3.11 Referrals will usually be received by the Social Worker on duty who should record immediately available details on the appropriate referral form.

3.12 The Social Worker will discuss the referral with the Social Work Manager/Senior Social Worker who will decide what action should be taken. The action agreed must be recorded by the Social Work Manager in the Family and Child Care Team.

3.13 In accordance with the protocol in place in the Trust the Social Worker must check if the child's name or the name of any other child in the same household is on the Child Protection Register and also check computerized and manual records. If, at a later stage, it comes to the attention of the Social Worker that another child in the household has a different surname, appropriate checks should be made.

3.14 If immediate action is not necessary to protect the child, the Social Worker will undertake initial inquiries. This will involve checks with a range of disciplines as outlined in Chapter 5.

3.15 The Social Work Manager will decide appropriate action on the basis of the initial enquiries and record the reasons for doing so.

3.16 When the referral indicates immediate danger to the child, the Social Work Manager in the Family and Child Care Team must ensure that appropriate and immediate protective action is taken. In all other cases, access to the child and a visit to the parent/carer should be planned as quickly as is consistent with effective investigation.

3.17 The PSNI will be consulted regarding the referral and a decision taken as to how the initial investigation will be carried out.

3.18 The investigating Social Worker must consider any child protection issues or other needs concerning other children in the household and include these children, if appropriate, as part of the investigation into the alleged abuse of the specific child.

3.19 The referral, and action agreed, should be confirmed in writing by the Social Work Manager in the Family & Child Care Team to the referrer within **5 working days** of the receipt of the referral. Receipt of a referral from a member of the public should also be acknowledged in writing within **5 working days**.

3.20 Arrangements should be made for the child to be medically assessed, as appropriate, if this has not already been undertaken because of an emergency situation. The parent/carer should, where appropriate, give consent for the child to be medically examined and accompany the child for medical examination. If the child is deemed to be 'Gillick' competent his consent should be sought before conducting a medical examination.

3.21 When the medical examination supports the view that the harm is significant and that the cause is probably abuse, the Social Work Manager in the Family and Child Care Team should take into consideration, in terms of the implications of these findings, the views of relevant agencies about the protection of the child from further harm.

3.22 Wherever possible, arrangements with regard to the protection of the child should be made through formal written agreement with the parent/carer. The views of the child should be taken into account although protection of the child from harm must be of paramount importance.

3.23 When the cause of the abuse is unknown and/or the parent/carer is unable to agree with the Social Worker as to the need for protection, consideration should be given to applying to Court for an Emergency Protection Order. Legal advice should be sought before an application for an Emergency Protection Order is sought.

3.24 The investigating Social Worker will prepare a written report for the Initial Child Protection Case Conference.

3.25 The investigating Social Worker will ensure that the parent/carer and child (where his age and level of understanding is sufficient for him to engage with the process) are invited to the Initial Child Protection Case Conference and that they are given written information about Child Protection Procedures. It is important to consider for the purposes of sharing written information throughout the child protection process whether parents have difficulty with literacy.

3.26 When the investigation does not result in a Child Protection Case Conference, the referrer as well as the family should be informed in writing by the Social Work Manager in the Family & Child Care Team about the outcome of the enquiries.

Social Workers in Other Teams and Settings within Health & Social Services Trusts

3.27 All social workers who have child protection concerns must immediately consult with their line manager who will liaise with the relevant Family and Child Care Manager. If, following consultation it is deemed appropriate that a child protection referral should be made, this should be done immediately and confirmed in writing within **24 hours.**

A record must be made of the discussion, decisions and agreed actions.

Where appropriate consideration will be given to joint working with family and child care social workers.

Role of Hospital Social Worker

3.28 Social Workers working in hospitals have an important and significant role in supporting and working with individual in-patients and out-patients and their families. They are also a valuable resource and link person with community social services for other disciplines working in the hospital setting. Hospital social workers are well placed to identify children in need and children in need of protection, whether working directly with children or with parents/carers/family members whose health may impact on the care of children. They should be aware of indicators of abuse and neglect and child protection procedures.

3.29 When a Social Worker working in a hospital setting has concerns about a specific child, these concerns should be discussed with his Line Manager. Nursing and medical colleagues should also be consulted in respect of their involvement with the child and any observations that might inform the hospital Social Worker's assessment. If, following consultation it is deemed appropriate by the Social Worker and his Line Manager that a Child Protection referral should be made, this should be done immediately and confirmed in writing within **24 hours**.

3.30 The hospital social worker will attend all multi-agency/multi-disciplinary meetings convened including strategy discussions, case planning, Case Conference and core group meetings.

3.31 A written report from the hospital social worker will be made available for the initial child protection Case Conference outlining his involvement with the family, assessment of the child's and parents needs and any concerns noted. If possible, a copy of this report should be shared with the family. The report should be with the Chairperson of the Case Conference **2 working days** prior to the meeting.

3.32 The hospital social worker will contribute to the multi-agency assessment of risk and to the child protection plan.

Social Services Out of Office Hours (Weekends, Bank Holidays, Evenings)

3.33 There is a Social Services Out-of-Hours provision in each HSS Board area (please refer to Appendix 3 for telephone numbers).

Co-ordinators/Emergency Duty Team responsible for provision of Out of Hours Social Services should:

1. Record as much information as possible from the person making the referral and ensure that the Child Protection Register is checked.
2. Be responsible for consulting with other relevant professionals in order to agree the initial action to be taken, by whom and when, and the arrangements for reporting back.
3. The timescale for responding to a child who may be suffering, or at risk of, suffering significant harm will be dictated by the circumstances of the particular case. However, the child and family must be seen by a Social Worker within **24 hours** of referral.
4. The Protocol for Joint Investigation by Police Officers and Social Workers of Alleged and Suspected Cases of Child Abuse (Joint Protocol) must be followed.
5. Arrange for a Social Worker to undertake the investigation, brief the worker with referral information and inform the Social Worker of the outcome of the strategy discussion. Particular care and sensitivity is required at such times to ensure that any investigation takes account of the child's circumstances, e.g. unless there is an immediate danger to the child, he should not have his sleep disturbed; or be removed from his home in the early hours of the morning.
6. Report to the relevant Social Work Manager in the Family and Child Care Team on the morning of the first working day after the referral.

3.34 **Social Workers** to whom a case has been referred by the Co-ordinator should take the following action:

1. Record as much information as possible from the person making the referral.
2. Visit and prepare an initial assessment of the situation.

3. Take any action considered necessary to protect the child from immediate or imminent harm.
4. Report back to the Out-of-Hours Co-ordinator immediately of the outcome of the visit.
5. In consultation with the Out-of-Hours Co-ordinator take any other action which is deemed necessary.
6. Ascertain the name of the Social Work Manager who will have responsibility for the case and immediately forward the relevant details in writing.

Registration and Inspection Unit Inspectors

Significant Events

3.35 In respect of events at any children's home where a child is accommodated child protection concerns may constitute significant events as defined in Regulation 19 of The Children's Homes Regulations (NI) 1996. Whilst the Child Protection enquiries/investigation will not be carried out by the Registration & Inspection Unit Inspector, he has a responsibility to take appropriate action when issues come to his attention.

3.36 Where an allegation of neglect, physical injury, sexual abuse and/or emotional abuse (e.g. between residents, a resident being abused by a member of staff or a resident being abused by a family member, friend, acquaintance or stranger) has been made to the Registration & Inspection Unit Inspector, or the Inspector has suspicions that this is the case, the following action must be taken:

1. The Registration and Inspection Unit Inspector must discuss his concerns with the Manager or Deputy Manager of the Residential Facility and immediately consult with his Manager in the Registration and Inspection Unit.
2. The Unit Inspector should make a verbal referral to the Social Work Manager in the Family and Child Care Team and follow up in writing within **24 hours**.
3. Where the alleged abuser is a professional colleague, the procedure entitled "Allegations of Abuse by a Professional, Carer or Volunteer" in Chapter 9 of these Procedures should be followed.

Disclosure of Abuse Prior to admission to a Children's Home

3.37 In the event of a child disclosing abuse to a Registration and Inspection Unit Inspector which occurred prior to the child's admission to the children's home, the Inspector should inform the Manager of the Residential Facility and discuss the situation with his Line Manager. The Inspector will refer the matter to the relevant Social Work Manager in the Family and Child Care Team.

The Inspector should confirm the referral in writing within **24 hours.**

Early Years and Children's and Families' Support Services

This can include the following:
Childminders
Day nurseries/Crèches
Family Centres
Family Support Staff
Home Helps
Out of School Clubs
Playgroups
Sure Start Projects.

3.38 Staff in these settings are likely to play an important part in helping parents under stress to cope with their child's behaviour, to support them and so prevent abuse. They may be well placed to observe signs of abuse, changes in behaviours or failure to develop. In offering direct help to children and their families and monitoring their care they may be essential in helping a family stay together.

3.39 Where staff, or volunteers, have child protection concerns about a child they must immediately inform the Manager of the service who will make a referral to the Social Work Manager in the Family and Child Care Team.

3.40 If a childminder has child protection concerns about a child he should immediately discuss this with the Social Worker who visits him or, if he is not available, the duty Social Worker within the Trust.

3.41 A record must be made by the Social Worker of the issues/concerns discussed and actions agreed.

Foster Carers

3.42 Some children in foster care may have been suspected or confirmed victims of child abuse when they first came into care. In other cases indications of abuse may become apparent only at a later date. The following procedures should be followed by foster carers.

1. If a foster carer is concerned or has suspicions that a child in his care has been or may have been abused, he should immediately consult the Social Worker who has responsibility for the child.
2. The foster carer should inform his named supervising Social Worker of the concern and any action taken.
3. The foster carer should make a written record of his concern, issues discussed, actions taken and ensure that this is shared with the supervising Social Worker.
4. In the absence of either of the above Social Workers, the foster carer should consult with the Social Work Manager of the Team with responsibility for the child.

Nurses

3.43 **All registered nurses and midwives must adhere to the Nursing and Midwifery Code of Professional Conduct which provides guidance and details on professional practice standards and accountability. Each nurse, midwife and health visitor is required to act at all times in such a manner as to safeguard and promote the interests of individual patients and clients.**

The role of Board Designated Nurse and Trust Named Nurse is detailed in paragraphs 3.20 and 3.21 of 'Co-operating to Safeguard Children'.

Community Nurses

3.44 The term 'Community Nurses' refers to nurses, midwives and health visitors and includes those employed by a community Health and Social Services Trust, a primary care service or in the private and voluntary sector.

Community Nurses are well placed to identify children in need and children in need of protection. They should be aware of the indicators of abuse and procedures to follow in the event of child care concerns. The Nursing and Midwifery Council Code of Conduct requires nurses to work in partnership with children, families and professional colleagues in promoting the health and well being of the population.

Action to be Taken by a Community Nurse in Cases of Suspected Physical, Sexual or Emotional Abuse and/or Neglect

3.45 The Community Nurse will:

1. Discuss concerns with the parent/carer and the child if appropriate, and inform them of any intended action unless this may place the child at risk of harm. He will, where possible, seek agreement to refer to the HSS Trust Family and Child Care Team. Parental agreement is not a requirement in terms of making a referral. However, the nursing response should not prejudice future investigations.
2. Arrange urgent medical consultation if required.
3. Discuss concerns with his manager and the named Nurse for

Child Protection. This must not delay an urgent referral to the Family and Child Care Team.

4. Make a verbal referral to the Social Work Manager in the Family and Child Care Team immediately. This will be followed up in writing within **24 hours**. Copies of the referral form will be forwarded to the Nursing Manager and named Nurse for Child Protection. A copy of the referral form will be retained in nursing records.

5. Inform the family health visitor and the general practitioner of concerns and actions taken, and where appropriate, other nursing colleagues and the child's/family member's medical consultant.

6. Document all observations, comments, discussions and liaisons in relation to concerns and actions taken, within **24 hours**.

7. Attend all multi-agency/multi-disciplinary meetings convened including strategy discussion, case planning, Case Conference and core group meetings.

8. Provide a written report for initial/review Child Protection Case Conference outlining his involvement with the family, assessment of the child's needs and any concerns. A copy of this report must be shared with the named Nurse for Child Protection prior to the Case Conference. If possible, the report should be shared with the family. A copy should be with the Case Conference Chairperson **2 working days** prior to the Case Conference.

9. Contribute to the multi-agency assessment of risk and to the Child Protection Plan.

10. Review the minutes/notes of meetings attended to ensure that these accurately reflect nursing contribution and agreement to multi-agency action plans. Amendments should be forwarded to the Chairperson within the agreed timescale.

Midwives

3.46 Midwives have a significant role to play by encouraging parents to take a responsible attitude to the care of their children and helping them to create an affectionate and positive relationship with their baby. They will have contact with parents during pregnancy, at birth

and may visit up to 28 days post-natally. Midwives need to identify and respond to unusual attitudes and behaviours in pregnancy and early parenthood which may impact on the safety of the children within the family.

Health Visitors

3.47 Health Visitors promote the health and well-being of individuals, families and groups. They provide a child health surveillance programme to all children under 5 years and offer support and advice regarding parenting. In some Trusts Health Visitors continue to provide a service to children over 5 years old and to their families where specific needs are identified.

3.48 Health Visitors are particularly well placed to identify and respond to the needs of vulnerable children and their families and are recognised as a key nursing professional in child protection. They have a critical role in the assessment of children at risk and actively contribute to multi-agency Child Protection Plans.

School Nurses

3.49 School Nurses promote the health and well being of school age children. They are members of the multi-agency school health team and offer a service to children who seek or need support, advice, counselling or information. This places them in a key position to identify and respond to the needs of vulnerable school-aged children. It is important that School Nurses are aware of children whose names are on the Child Protection Register and contribute to the multi-agency Child Protection Plans where appropriate.

Community Children's Nurses

3.50 Community Children's Nurses work mainly with sick children and may have contact with children who have developmental needs, life limiting conditions or those who have been abused or are at risk of abuse or neglect. Increasingly, children with more complex needs are being cared for at home and Community Children's Nurses must be aware of the pressure this places on families. Community Children's Nurses are well placed to identify and respond to the needs of all the children in the family.

Learning Disability Nurses

3.51 Learning Disability Nurses are well placed to identify and respond to the increased vulnerability and potential risk of abuse to children with special needs. They promote positive parenting and ensure, in liaison with other professionals, the provision of appropriate support and a safe living environment for the child, enabling the child to reach his full potential.

District Nurses

3.52 District Nurses primarily work with the adult population. As a home visiting service, however, they are well placed to identify and respond to the needs of children, including those affected by the illness of a family member. When a child becomes a carer, District Nurses should assess the potential impact on the child and refer to the appropriate services for further assessment.

Practice Nurses/Treatment Room Nurses/Nurse Practitioners

3.53 As part of the Primary Care Team, Practice Nurses, Treatment Room Nurses and Nurse Practitioners frequently come into contact with children and their carers. They are well placed to identify the needs of vulnerable children. It is important that the impact on children of illnesses, injuries and the explanations given are considered.

Family Planning Nurses

3.54 Family Planning Nurses provide a service to young people and adults and are in a position to promote health including a positive attitude to sexual health. They are well placed to identify and respond to the needs of young people who are at risk of sexual exploitation and other forms of child abuse.

Nurse Specialists

3.55 Nurse Specialists provide a diverse range of services in a variety of settings to children and their parents. They must be able to identify and respond to situations where children may be vulnerable or at risk, for example a Diabetic Nurse Specialist may become aware that a child's diabetes is not being controlled as a result of inappropriate administration of insulin.

Mental Health Nurses

3.56 Mental Health Nurses provide services to children, adolescents, adults and families in a range of settings. There is a wide range of services that includes cognitive behavioural therapy, child and adolescent mental health services, counselling services and addiction services.

3.57 Mental health issues and/or a psychiatric disorder can affect a parent's ability to safeguard his children resulting in varying degrees of abuse, neglect and emotional deprivation of children. Mental Health Nurses have a responsibility to identify and respond to the risks that an adult may present to children as a consequence of his mental health needs. If a Mental Health Nurse has a child protection concern regarding a patient he should immediately bring this to the attention of his line manager and the Doctor responsible for the patient's care and consider what appropriate action to take in line with these procedures. A written report should be made in the patient's notes of such concerns and the action taken.

3.58 Child and Adolescent Mental Health Nurses are well placed to identify and respond to the needs of children and adolescents who experience mental health problems. Child and Adolescent Mental Health Nurses have a crucial role in providing therapeutic services and expert mental health input to the multi-agency child protection team.

Occupational Health Nurses

3.59 Occupational Health Nurses promote the health and social well-being of those in employment. They need to consider how adult health and social issues may affect the care of children.

Nurses Working in Hospitals

3.60 The term 'Hospital Nurses' refers to all nurses and midwives employed in a Hospital by an HSS Trust or those employed by the private or voluntary sector.

3.61 Hospital Nurses are well placed to identify children in need and children in need of protection, whether working directly with children or with parents/carers/family members whose health may impact on the care of children. They should be aware of indicators of abuse and neglect and Child Protection Procedures. The Nursing and

Midwifery Council Code of Conduct requires Nurses to work in partnership with children, families and professional colleagues in promoting the health and well being of the population.

3.62 Nurses working in hospitals need to be aware that children and their parents/carers may attend a number of health and medical facilities in order to conceal the repeated nature of their child's injuries. The Hospital Nurse should know how to access information from the Child Protection Register (refer to section 7.8).

3.63 The named Nurse for Child Protection in the hospital must have mechanisms in place to ensure that nursing staff are made aware of those children for whom there are Child Protection concerns, so that the nursing plan takes account of the diagnosis and assessment.

Action to be Taken by the Hospital Nurse in Cases of Suspected Physical, Sexual or Emotional Abuse and/or Neglect.

3.64 The Hospital Nurse will:

1. Discuss concerns with the parent/carer and the child, if appropriate, and inform them of intended action unless this may place the child at risk of harm. The Hospital Nurse will, where possible, seek agreement to refer to family and child care/Social Services. Parental agreement is not a requirement in terms of making a referral, however. The nursing response should not prejudice future investigations.
2. Arrange urgent medical consultation if required.
3. Discuss concerns with his manager, the doctor responsible for the patient's care and the hospital Social Worker and inform the named Nurse for Child Protection. This must not delay an urgent referral to the Family and Child Care Team.
4. Check hospital records for previous attendances or admissions and obtain information from the Child Protection Register via the Hospital Sister, if appropriate.
5. Contact the Police or Social Services immediately where it is believed that a child is at immediate risk of abuse and parents are threatening to remove the child from the Facility.

6. Make a verbal referral to the Social Work Manager in the Family and Child Care Team during normal office hours. Outside of these hours, if the referral is urgent, a verbal referral must be made to the Out-of-Hours Social Work Service immediately. Verbal referrals should be followed up in writing within **24 hours**. Copies of referral forms should be forwarded to the Nursing Manager and named Nurse for Child Protection. A copy of the referral form will be retained in nursing records.

7. Confirm that a child who has been transferred to another ward or hospital has arrived as planned by contacting the receiving ward or hospital. If the child did not arrive as expected, the Hospital Social Worker/ Social Work Manager in the Family & Child Care Team must be informed immediately, or if outside office hours, the Out-of-Hours Social Work Service.

8. Inform the family health visitor, general practitioner and appropriate nursing colleagues of concerns and actions taken as soon as possible.

9. Document all observations, comments, discussions and liaisons in relation to concerns and actions taken before going off duty.

10. Attend all multi-agency/multi-disciplinary meetings convened including strategy discussion, case planning, Case Conference and core group meetings.

11. Provide a written report for the initial Child Protection Case Conference outlining his involvement with the family, assessment of the child's needs and any concerns. A copy of this report must be shared with the named Nurse for Child Protection prior to the Case Conference. If possible, the report should also be shared with the family. A copy should be with the Chairperson **2 working days** prior to the Case Conference.

12. Contribute to the multi-agency assessment of risk and to the Child Protection Plan.

13. Review the minutes/notes of meetings attended to ensure that these accurately reflect the nursing contribution and agreement to multi-agency action plans. Amendments should be forwarded to the Chairperson within the agreed timescale.

NB Please refer to Child Protection in hospital settings in Chapter 9.

Professionals Working in Mental Health Settings (Children & Adult Services)

This can include the following:
Psychiatrists
Psychologists
Mental Health Social Workers
Mental Health Nurses (please follow action to be taken by community nurses and nurses working in hospitals).

3.65 Children of parents who have a psychiatric condition may be considered as vulnerable and in need of additional support.

There may also be a link in some instances between parental psychiatric disorder and child abuse. This can result in varying degrees of abuse of children by a parent suffering from a psychiatric illness as well as the possible neglect and emotional deprivation of children whose parents suffer from chronic psychiatric conditions.

3.66 A small minority of mental health patients may present a physical or sexual risk to children in the wider community. Medical, nursing, social care personnel and allied health professionals who work in mental health services will have an important role in the protection of children whose parents suffer from mental illness. Their involvement is crucial in regard to two main issues:

- the assessment of the risks a patient may present to children as a consequence of a psychiatric condition and individual circumstances
- the potentially harmful consequences, on a dependent child's social and emotional development, of a parent's long-term psychiatric condition.

It is important therefore that there is an explicit policy within mental health services about:

- the need to obtain information relating to dependent children
- the need to clarify a patient's contact with children
- the need to consider this information as a crucial part of the case planning process.

3.67 **Mental Health Service Personnel should follow the procedures set out below**

1. In situations where the psychiatric condition of a parent may have consequences on his ability to provide adequate and appropriate care for children within the family, the mental health service professional should discuss his concerns with his manager, the doctor responsible for the patient's care and the hospital social worker and inform the named nurse and doctor for child protection. This though must not delay any urgent referral to the Family and Child Care/Team.

2. Where, after consultation, concern remains, an immediate verbal referral must be made to the Social Work Manager in the Family and Child Care Team during normal office hours. Parents should normally be informed that a referral is being made and colleagues in the hospital social work team informed. Outside of normal office hours, if the referral is urgent, a verbal referral must be made to the Out of Hours Social Work Service immediately)please refer to Appendix 3 for the telephone numbers within each Board area). Verbal referrals should be followed up in writing within **24 hours.** The Family and Child Care Team can then undertake an assessment of the child's and family's need for support services in co-operation with the mental health services, the patient and the family.

3. Where a professional in the Mental Health Services has concerns that a patient may present a risk to a child, he should consult with his Line Manager. If there are child protection concerns, the Line Manager will make a verbal referral to the Social Work Manager in the Family and Child Care Team and inform the hospital social worker. The referral, which should be confirmed in writing within **24 hours** should include details of the factors constituting risk.

4. The Psychiatrist or other member of the Mental Health Team responsible for the case should attend all Case Conferences. If arranged, they should provide a written report of the patient's condition including an assessment regarding any risks the patient may present to children and contribute to the Child Protection Plan, as appropriate.

5. This section should be read in conjunction with Chapter 5.

The General Medical Council (GMC) Guidance entitled "Confidentiality, Protecting & Providing Information" (2004) should be followed.

Allied Health Professionals (AHPs)

Allied Health Professionals will include the following;

Physiotherapy
Occupational Therapy
Speech & Language Therapy
Nutrition & Dietetics
Podiatry
Orthoptics
Psychology
Radiography
Audiology
Dentistry
Pharmacology
Optics/Optometry

3.68 Given the multi-disciplinary nature of child protection work, the involvement of health professionals is crucial to good child care practice. All the above professionals have an important role to play in relation to providing services to families and children where there are concerns about children's health and development. They can provide crucial information about particular aspects of children's conditions, injuries, behaviour, needs, communication requirements and skills, nutrition and physical ability. These staff through regular contact with and in-depth knowledge of children have a vital role to play in the identification of concerns about possible abuse.

Allied Health Professional Staff Working in Hospital and Community Settings

3.69 Action to be followed by AHP in cases of suspected physical/sexual/ emotional abuse/neglect:

1. Record immediately and precisely
   (i) observations made
   (ii) exactly what the child has communicated through speech or an alternative communication system
2. Discuss concerns with his Line Manager to ascertain next steps to be taken (and in hospital settings the doctor responsible for the patient's care and the hospital social worker). If the Line Manager is not available, consult with

another senior member of staff. This must not delay any urgent referral to Family and Child Care/Team.

3. If, after this consultation concern remains, the concern should be discussed with the Social Work Manager in the Family and Child Care Team.

4. Make a referral to Family and Child Care Team, as appropriate (and in hospital settings notify the doctor responsible for the patient's care and the hospital social worker). A verbal referral must be followed up within **24 hours** with a written referral.

5. The AHP must make a record of all discussions held, actions taken and advice given within **24 hours.**

6. The AHP should provide a written report and attend any Case Conference to which invited.

3.70 Allied Health Professionals Working in Educational Establishments

1. Record immediately and precisely

   (i) observations made

   (ii) exactly what the child has communicated through speech or an alternative/ augmentative communication system

2. Consult with the Line Manager without delay to ascertain next steps to be taken. If the Line Manager is not available, consult with another senior member of staff.

3. The AHP should inform the School Principal and/or Designated Teacher for Child Protection of his concern.

4. If, after consultation with the above the concern remains, the AHP should discuss the concern further with Social Services.

5. Make a referral to Social Services as appropriate. Verbal referral must be followed up immediately with a written referral within **24 hours.**

6. The Professional must make a record of all discussions held, actions taken and advice given within **24 hours.**

7. The AHP should provide a written report and attend any Case Conference to which he is invited.

Roles and Responsibilities of Medical Staff

- **Board Designated Doctor for Child Protection**
- **Trust Named Paediatrician for Child Protection**
- **General Medical Practitioners**
- **Forensic Medical Officers**
- **Community Paediatricians**
- **Hospital Paediatricians**
- **In-Patients, Out-Patients at Clinics and in Accident and Emergency Departments**

3.71 Child abuse may present in a variety of complex and intricate ways. **Where there is clear evidence of abuse or if an allegation has been made of abuse there should be no delay in referring the child immediately to Social Services.**

3.72 Where uncertainty exists doctors often find it helpful to test out professional hypotheses before sharing concerns with non-medical colleagues. Doctors should clarify their own thoughts about a particular case, and with advice as appropriate from senior or more experienced colleagues, decide upon the need to refer the child to Social Services. When a critical threshold of professional concern is reached doctors must immediately share these concerns with Social Services for further evaluation. (Ref.: GMC Guidance "Confidentiality: Protecting & Providing Information" 2004).

If in doubt medical practitioners are advised to discuss their concerns with senior paediatric colleagues.

Board Designated Doctor for Child Protection-
Trust Named Paediatrician for Child Protection-

The responsibilities of the Board's designated Doctor and Trust Named Paediatrician for Child Protection are outlined in paragraphs 3.17 – 3.19 of 'Co-Operating to Safeguard Children'.

General Medical Practitioners

3.73 Primary Care staff need to be alert to situations where children are intentionally brought to see a variety of doctors in the Practice, or when children are brought only to the Out-of-Hours service. If this

pattern of attendance is present Practices should review the reasons for attendance, consider the possibility of abuse and seek advice from a senior paediatrician.

To obtain further advice and assessment regarding alleged or suspected child abuse GPs must be aware of the local procedures for contacting a senior paediatrician (see appendix 2), Police or Social Services both during the working day and out-of-hours.

GPs should refer children to A+E Departments only if their clinical condition necessitates emergency treatment. In the event of this being required a senior paediatrician should also be contacted.

1. Physical Injury

- The GP is often presented with, or requested to carry out an assessment of, minor physical injuries. If on initial assessment the injury is not felt to be compatible with the explanation given or is suggestive of abuse, the case should be immediately discussed with a senior paediatrician. Where applicable, following this discussion, further medical assessment should be undertaken by a senior paediatrician.

- At the stage where a medical assessment confirms the likelihood that abuse has occurred, the doctor carrying out this assessment (who may either be the GP or senior paediatrician) must immediately refer the case to Social Services.

- The GP should consult the Child Protection Register to establish if the child is currently the subject of an inter-agency Child Protection Plan (refer to chapter 5).

- The absence of the child's name on the Child Protection Register should not be used to reassure the GP that no further action is required by him .

- Detailed, contemporaneous records of all injuries should be noted and discussions including explanations given for the injuries should be kept.

- The GP should attend any strategy meeting /Case Conference about the child to which he is invited or if

unable to attend, should provide a written report to the Chairperson at least **2 days** prior to the meeting.

2. Sexual Abuse

- Children may present to the GP with signs and symptoms suggestive of sexual abuse or make an allegation or disclosure of such abuse.

- **At this stage it may be inappropriate to examine the child as this may interfere with possible forensic evidence/joint protocol investigation (especially with an allegation or disclosure). It is likely that the child will require expert examination. The GP should immediately discuss the case with a senior paediatrician.**

- In the case of a child making an allegation/disclosure of sexual abuse, the GP must immediately contact Social Services to initiate a strategy discussion regarding further assessment/investigation.

- Any general examination which is undertaken should be only for the purpose of establishing the need for immediate investigation/treatment. Detailed ano-genital examination should be carried out only by a medical professional who has specific expertise in assessing child sexual abuse

- The GP should consult the Child Protection Register to establish if the child is currently the subject of an inter-agency Child Protection Plan (refer to chapter 5).

- Detailed, contemporaneous records of any general examination undertaken and all discussions should be kept.

- In cases of recent (less than 7 days) alleged or suspected sexual abuse the child should not be washed until paediatric forensic examination has been carried out and discarded underwear/clothing should be placed in a sterile plastic bag, sealed and marked with the child's details, time, date and name of person receiving the item.

- The GP should be aware that if during an examination of a child he has concerns that the child may have been/is being sexually abused, he will be required to provide a written report to Social Services as soon as possible.

- The GP should be aware that he may be required to provide evidence in court if legal proceedings are subsequently initiated.

- The GP should attend any strategy meeting /Case Conference about the child to which he is invited, or if unable to attend should provide a written report to the Chairperson at least **2 days** prior to the meeting.

Forensic Medical Officers (FMO)

3.74 Forensic Medical Officers will be requested to examine children by the Police either following a strategy discussion or as a result of a single agency (Police) investigation.

3.75 The aim should be, where possible, to carry out a joint medical assessment (FMO and senior paediatrician) in all cases of alleged or suspected child abuse where joint protocol procedures have been initiated. Any exception to this arrangement should be decided at strategy discussion and any single doctor assessment should be carried out in accordance with “Guidance on Paediatric Forensic Examinations in relation to possible Child Sexual Abuse” RCPCH and APS April 2002.

3.76 In the case of alleged or suspected sexual abuse the medical assessment should be undertaken by a senior paediatrician and/or FMO who between them, or individually, have the necessary core and case dependent skills required as defined in “Guidance on Paediatric Forensic Examinations in relation to possible Child Sexual Abuse” RCPCH and APS April 2002.

Refer to Chapter 8 for detailed information on the medical assessment.

Community Paediatricians

3.77 Community Paediatric Medical Staff are involved with the care of children in a variety of settings.

Staff will vary in their level of expertise and experience with regards to the assessment and management of Child Protection issues/concerns.

Staff may encounter Child Protection concerns either during the course of routine work within a clinic, school or home visit or at the request of Social Services.

Action to be taken in cases of alleged or suspected abuse include:-

3.78 **Situation where person with parental responsibility is present –** refer to Section 8.3 and if suitably qualified and holding the required level of expertise the Doctor may carry out the medical assessment as per chapter 8.

The Doctor should consult the Child Protection Register to establish if the child is currently the subject of an inter-agency Child Protection Plan (refer to chapter 5).

Otherwise seek advice on further assessment/management from the line manager, senior paediatrician or Trust's named Doctor.

3.79 **Situation where person with parental responsibility is not present –** Within a health setting the doctor should establish and document the concern from the child or relevant person(s) present. They should then consult with the line manager, senior paediatrician or the Trust's named doctor (if required).

If within a school setting the Designated Teacher for Child Protection/School Principal should be consulted and intended actions agreed.

- The doctor should consult the Child Protection Register to establish if the child is currently the subject of an inter-agency Child Protection Plan (refer to chapter 5).

Consult with Social Services and make a referral (as appropriate). Consideration must be given to involving the person with parental responsibility and seeking their consent to medical assessment - refer to Section 8.3 and if suitably qualified and holding the required level of expertise, the Doctor may carry out the medical assessment as per chapter 8.

Otherwise seek advice on further assessment/management from the line manager, senior paediatrician or Trust's named doctor.

Detailed, contemporaneous records of all discussions and examinations must be kept.

Hospital Paediatricians

3.80 If a case of abuse is suspected (following initial assessment) or alleged, the Consultant Paediatrician on call should be informed immediately. Refer to Chapter 8 for details on assessment.

3.81 Detailed, contemporaneous records of all examinations and discussions should be kept.

3.82 Should the person with parental responsibility refuse to allow the child to be admitted to hospital, or wish to discharge the child against medical advice and there is reason to believe that the child needs to be safeguarded, the appropriate social worker or duty social worker must be immediately contacted, as it may be necessary to obtain an Emergency Protection Order to safeguard the child. In the event of the doctor considering that the level of danger to the child would be life-threatening then the PSNI must be contacted to provide immediate Police Protection.

3.83 The doctor should consult the Child Protection Register to establish if the child is currently the subject of an inter-agency Child Protection Plan (refer to chapter 5).

3.84 In cases of recent (less than 7 days) alleged or suspected sexual abuse the child should not be washed until paediatric forensic examination has been carried out and discarded underwear should be placed in a sterile plastic bag and sealed and marked with the child's details, time, date and name of person receiving the item.

Children Presenting to Hospital Outpatient (including A+E Dept) or Inpatient Departments (including Family Planning Service)

3.85 When a case of child abuse is suspected or alleged in a hospital setting the doctor should inform the Consultant responsible for the case or his line manager and consult the hospital social worker. A senior Paediatrician should immediately be consulted for advice and referral made to the Social Work Manager in the Family and Child Care Team. This also applies to adolescents in the 14-17 year age group who may be admitted to adult wards.

3.86 Any general examination which is undertaken should only be for the purpose of establishing the need for immediate investigation/ treatment. The Paediatrician will liaise with the responsible Consultant/Line Manager about who is the most appropriate person to carry out the medical assessment (Refer to chapter 8).

3.87 The examining doctor should share the outcome of the medical assessment with the GP. A careful record should be kept of all discussions.

3.88 The doctor should consult the Child Protection Register to establish if the child is currently the subject of an inter-agency Child Protection Plan (refer to chapter 5).

3.89 In the case of children presenting with signs and symptoms suggestive of sexual abuse or an allegation or disclosure, **it may not be appropriate to examine the child at all as this may interfere with possible forensic evidence/joint protocol investigation (especially with an allegation or disclosure). It is likely that the child will require expert examination. The doctor should discuss the case immediately with a senior Paediatrician.**

3.90 In the event of presentation with an allegation or disclosure of sexual abuse the doctor must immediately refer the case to Social Services and be aware that at a later date he may be required to provide evidence in court if legal proceedings are subsequently initiated.

3.91 Any general examination which is undertaken should be only for the purpose of establishing the need for further immediate investigation/treatment. Detailed ano-genital examination should not be carried out without specific expertise in assessing child sexual abuse. In all circumstances examinations should be arranged in accordance with the “Protocol for Joint Investigation by, Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse” (Joint Protocol).

3.92 A detailed, contemporaneous record of any examination undertaken and all discussions should be kept.

3.93 In cases of recent (less than 7 days) alleged or suspected sexual abuse the child should not be washed until paediatric forensic examination has been carried out and discarded underwear should

be placed in a sterile plastic bag, sealed and marked with the child's details, time, date and name of person receiving the item.

3.94 Should the person with parental responsibility refuse to allow the child to be assessed or wish to discharge the child against medical advice and there is reason to believe that the child needs to be safeguarded, the appropriate social worker or duty social worker must be immediately contacted, as it may be necessary to obtain an Emergency Protection Order to protect the child. In the event of the doctor considering that the level of danger to the child would be life-threatening then the PSNI must be contacted to provide immediate Police Protection.

NB: Please refer to child protection in hospital settings in Chapter 9

Ambulance Staff

3.95 If a member of ambulance staff is concerned that significant harm may have occurred or is occurring to a child, action should be taken as follows:

1. If urgent medical attention is required arrange for the child to be taken to the hospital accident and emergency department immediately. Suspicion of abuse should be notified directly to a senior member of the A&E department staff who will be responsible for liaising with the relevant Social Work Manager in the Family and Child Care Team.
2. If urgent medical attention is not required but there is concern about abuse, ambulance staff should discuss the suspicion of harm immediately with the relevant Social Work Manager in the Family and Child Care Team or the Out-of-Hours Social Services Co-ordinator. (Appendix 3 provides contact details.) The purpose of this discussion will be to enable the Social Work Manager to determine the immediate steps to be taken in the investigation of the referral.
3. The member of ambulance staff should be prepared to attend any meetings and subsequent Case Conference, which may of necessity be arranged at short notice.
4. A detailed record should be made by ambulance personnel of all findings, actions and observations.

Education

Grant-aided Schools[6]

3.96 Schools are in a position to promote and safeguard the welfare of all children.

Child protection in schools has three main elements:

- through the curriculum pupils are encouraged to develop strategies to keep safe
- through vetting to ensure that only suitable persons work with pupils
- through responding appropriately when child abuse concerns are raised about an individual pupil.

All schools should have a named Designated Teacher for child protection and named Deputy Designated Teacher. The Designated Teacher acts as a focal point for child protection within the school through providing advice and support to staff and by liaising with agencies outside the school as appropriate.

3.97 All grant aided[6] schools are required by law to have a child protection policy and to implement it.

A school, when preparing its policy, must take into account the most recent advice from:

- The Department of Education (DE)
- the relevant Education and Library Board (ELB)
- In the case of Catholic maintained schools, the Council for Catholic Maintained Schools (CCMS).

Written advice to schools on child protection matters is issued by means of a DE Circular. All advice issued by the Dept of Education is consistent with the 'Co-operating to Safeguard Children' document and the ACPC Regional Policies and Procedures. Training on child protection matters is organized by the Education and Library Boards (ELB) and is available to members of Boards of Governors, school principals, designated teachers and their deputies.

6 Grant-aided schools covers those nursery, primary and secondary level schools which are publicly funded and normally described as controlled, Catholic maintained, integrated, Irish medium or grammar

Staff in schools can also obtain advice about child protection matters in general and support with specific issues from the Designated Officer for Child Protection at the relevant ELB or from the Designated Officers at CCMS.

The arrangements for pastoral care and child protection in schools are subject to inspection by the Education and Training Inspectorate (ETI).

3.98 Procedures to be followed:

1. Where there is cause for concern about a child, the teacher or other member of staff should consult the Designated Teacher.
2. The Designated Teacher will consult with the Principal and together they will agree the subsequent action and who will undertake it. This will normally be the Designated Teacher.
3. The Designated Teacher may seek advice from the Designated Officer for Child Protection at the relevant Education and Library Board and/or local Social Services.
4. When the decision to refer is made, the Designated Teacher should make the referral to Social Services in writing, using the standard referral form. This form should be copied to the Designated Officer for Child Protection in the relevant Education and Library Board.
5. A parent/carer is told by the School that a referral is to be made to Social Services unless the parent/carer is the subject of the allegation.
6. The Designated Teacher should make a record of all the discussions held and actions taken within **24 hours** of a referral.
7. If an acknowledgement of the referral is not received from Social Services within **5 working days**, then the Designated Teacher should follow this up.
8. After referral, schools and ELB staff will co-operate with the child protection investigation. This can involve providing factual information about the pupil for the purposes of the multi-agency assessment of risk and the Child Protection Plan. School staff may be invited to contribute to a Child Protection Case Conference if appropriate.

Independent Schools

3.99 Independent Schools receive no public funding and are not subject to the same legal requirements as grant-aided schools. However, they must register with the DE and to sustain that registration must adhere to minimum child protection standards, including the promotion of pupil welfare and child protection. The provision is inspected at regular intervals by the ETI. Advice and support is available on request through the Designated Officers at the ELBs.

Youth Services

3.100 Each youth organization and club should have a child protection policy that is specific to the needs of the unit. It should outline:

- how young people's welfare will be safeguarded
- how staff will be recruited, selected, supported and managed
- how concerns about possible abuse will be dealt with
- state the named designated member of staff to whom concerns should be reported.

3.101 The method of referring suspected cases to the appropriate authorities varies depending on whether the unit is a statutory or voluntary provision. Support for all groups however is available through the designated youth service officer in the local ELB or through the appropriate Headquarters contact for the organization.

Police Service of Northern Ireland

3.102 Police involvement in cases of child abuse stems from their primary responsibilities to protect life, to prevent and investigate crime and to instigate criminal proceedings, albeit that the welfare of the child is the prime consideration. In the spirit of working together the Police focus will be to determine whether a criminal offence has been committed, to identify the person or persons responsible and to secure the best possible evidence in order that appropriate consideration can be given as to whether criminal proceedings should be instituted. Failure to conduct child abuse investigations in the most effective manner may mean that the best possible protection cannot be provided for children. Although the Police may instigate proceedings, it is the responsibility of the Department of Public Prosecutions to review and, where appropriate, conduct all criminal prosecutions.

3.103 The evidential requirement of the criminal courts is proof beyond reasonable doubt that the defendant committed the offence. Proceedings for the protection of children under the Children Order takes place in the civil court where decisions are made on the balance of probabilities, which is a lesser standard of proof.

3.104 This may mean that if the Director of Public Prosecutions[7] (DPP) decides not to prosecute, or if a criminal court fails to convict a person suspected of child abuse, nevertheless a civil court may still decide that there is evidence to show that the child is suffering or likely to suffer significant harm in accordance with Article 50(2) of the Children Order.

Irrespective of the DPP's decision concerning prosecution the Police will gather, or be in possession of, information highly relevant to a decision about a child who may be in need of protection from abuse.

3.105 This should be read in conjunction with Chapters 5, 6 and 7 of these procedures and the Joint Protocol.

1. All allegations of child abuse must be referred to the PSNI's Child Abuse and Rape Enquiry (CARE) Units which will carry out investigations as appropriate. These Units contain

[7] It is planned to change this title to Public Prosecution Service (PSS) in 2005

specially selected and trained officers with aptitude for and expertise in dealing with victims of child abuse.

2. The Police will not act unilaterally except in emergency situations where immediate steps are necessary to protect the safety of a child or where there is a need to gather evidence urgently. They will normally carry out their investigation in consultation with Social Services in accordance with the 'Protocol for Joint Investigation of Alleged and Suspected Child Abuse'.

3. The Police have a range of powers, not available to other agencies, to afford protection to children without prior application to a court. In certain circumstance the Police have powers of entry and search. In cases where Social Services identify a need for immediate action (the situation is so urgent that there is insufficient time to seek or await the outcome of an application for an Emergency Protection Order), requests should be made to Police to consider use of Article 65 of the Children (NI) Order 1995 (Police Protection) and the Police and Criminal Evidence (NI) Order 1989 (PACE) powers pending an Emergency Protection Order. Where in an emergency situation a child requires police protection under Article 65 of the Children (NI) Order 1995, all PSNI Inspectors are deemed to be designated officers.

4. Where a medical examination is required, police will liaise with a Forensic Medical Officer who will advise on the appropriate arrangements for medical examination in order to minimise any potential distress caused to the child.

5. The investigating officer or his nominee will attend all Initial Child Protection Conferences and subsequent Case Conferences as appropriate. After receiving details of those involved, the officer will bring to the Conference details, as appropriate, of any relevant background checks that have been made.

6. Routine liaison between Police and Social Services will be with the CARE Unit Det/Sergeant or other person in charge of the office at that time. Any liaison regarding the operation of procedures in a particular case should normally be directed to the Det/Inspector in charge of that CARE Unit.

NB: The above procedures should also be read in conjunction with the Children's Evidence (NI) Order 1995; Achieving Best Evidence; and the Protocol for Joint Investigation by, Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse; and Chapters 5, 6 and 7 of these procedures.

NSPCC

3.106 The NSPCC (National Society for the Prevention of Cruelty to Children), as a voluntary agency, has statutory powers and responsibilities to protect children.

The protection of children is the NSPCC's primary task. The NSPCC employs professionally qualified Social Workers to work with children. The Society is empowered to carry out its duties and provide a service to children under a Royal Charter. It is enabled to bring children before the Court by virtue of its Officers being "authorised persons" under the terms of the Children Order.

3.107 The NSPCC is a member of the ACPC and endorses its policies and procedures. NSPCC is also represented on HSS Trust Child Protection Panels.

3.108 The NSPCC has developed services to complement Trusts in relation to complex and large scale investigations or where a Trust requires an element of independence.

The protection of the child is paramount. If, for any reason, another agency cannot respond, or if the referrer insists specifically on NSPCC response, the Society will undertake the investigation.

In the event of undertaking an investigation, checks will be made with Social Services and the Police and a joint discussion will take place about the matter to be investigated. The investigation will proceed according to the procedures in Chapter 5 of these Procedures.

3.109 The NSPCC provides a free telephone helpline 24 hours a day. Experienced Social Workers take referrals, counsel parents and children and will also offer advice to anyone concerned with the welfare of a child or children.

Probation Board for Northern Ireland

3.110 The Probation Board for Northern Ireland (PBNI) is committed to using appropriate resources in implementing its Child Protection procedures in partnership with other agencies. PBNI will ensure that all its staff are alert in their routine work in identifying indicators of significant harm or the likelihood of significant harm and will notify Social Services of all cases coming to its notice.

3.111 When a Probation Officer becomes aware of a case of confirmed, suspected or potential abuse he will:

1. Discuss the concern/facts with the Area Manager. In his absence the discussion must be with the regional Assistant Chief Probation Officer or other member of Senior Management.
2. Where discussion confirms the need for a referral, the referral to Social Services will be verbal in the first instance and followed up in writing within **24 hours.**
3. Any unresolved difference of opinion between the Probation Officer and the Area Manager as to the relevance of the referral or action necessary must be referred to the regional Assistant Chief Probation Officer immediately.
4. In all cases the referral must be made to the appropriate Social Work Manager in the Family and Child care Team in the HSS Trust. Social Services will be responsible for notifying the Police.
5. The Probation Officer should participate in strategy discussions and/or Case Conferences as appropriate.
6. Where appropriate, the Probation Officer should agree and implement, with an abuser or suspected abuser, any programme endorsed by the Case Conference. This may include the provision of accommodation or assessment issues.

Youth Justice Agency

3.112 The Youth Justice Agency is committed to the protection of children from abuse. All children, staff, parents and representatives of other agencies who use or have contact with our services are encouraged to be alert to and report any concerns about abuse. All concerns, whether past or present, will be responded to in keeping with the Youth Justice Agency Child Protection Policy and Procedures.

3.113 The Youth Justice Agency Child Protection Policy and Procedures sets out guidelines in such areas as reporting suspected abuse, dealing with allegations made against a member of staff, investigation of cases of child abuse, prevention and awareness raising and recruitment and selection of staff.

3.114 Where Youth Justice Agency staff become aware of a case of confirmed, suspected or potential abuse, they must bring this to the attention of their line manager and the designated officer for Child Protection. Initially this can be done verbally but then it must be followed up in writing. This communication must be acknowledged, in writing by the designated officer. The designated officer must then make an immediate verbal referral to the Social Work Manager in the Family and Child care Team in the HSS Trust, which should be followed up in writing within **24 hours** and also requesting that the referral be acknowledged in writing.

3.115 The designated officer should verify facts, advise and support staff and children and liaise with social services and the police. No form of internal inquiry should take place until the joint protocol enquiries have been conducted as it may prejudice the investigation.

3.116 When invited and where appropriate, Youth Justice Agency staff should participate in strategy discussions, Case Conferences and child protection plans. They may also have a role in supporting children and families through these processes.

3.117 In line with the Youth Justice Agency Child Protection Policy and Procedures, Youth Justice Agency staff will become involved in Board Area Child Protection committees and Trust Child Protection panels in order to ensure a co-ordinated approach to child protection across agencies and particularly with social services and the police.

Armed Services Arrangements for Child Protection

3.118 The life of a Service family differs in many ways from that of a family in civilian life. The employing service, specifically the Commanding Officer, is responsible for the welfare of Service Families.

3.119 HSS Trusts have the statutory responsibility for the protection of children of Service families based in Northern Ireland. The Armed Services are fully committed to co-operation with statutory and other agencies in supporting families in these situations and have in place procedures to help safeguard children. The welfare of families is monitored by the Personal Welfare Service of the Soldiers, Sailors and Airmen's Families Association (SSAFA) which consists of qualified Social Workers and Army Welfare Workers.

3.120 In the event of concern that a child has suffered significant harm, or is at risk of such harm the role of the Armed Services Authorities, predominantly via Personal Welfare Service, is to:

- make an immediate referral to the Social Work Manager in the Family and Child care Team which should be followed up in writing within **24 hours**
- share relevant information
- attend Case Conferences and contribute to Child Protection Plans as appropriate.

3.121 Personal Welfare Service staff also represent the Armed Services perspective on their local ACPC, Child Protection Panels and Domestic Violence Forums. This enables clear communication networks and opportunities for closer working relationships with the service community and statutory services.

3.122 Detailed guidance with regard to the Army, the Royal Navy and the Royal Air Force, including the relevant points of contact, is included in Appendix 1 of 'Co-operating to Safeguard Children'. Telephone numbers have changed, however, and are included in Appendix 3 of these Procedures.

The Voluntary and Community Sector

3.123 A wide range of Voluntary Agencies, Churches and Community organisations work with children and young people and provide services to help parents and other adults, some of whom may be under stress. Whilst these organisations play a valuable role in supporting families, it is important that they have a clear response when a child has suffered significant harm or is thought likely to suffer significant harm.

3.124 All voluntary and community sector organisations working with children and families must have clear Child Protection Policy and Procedures in place and staff should receive training in their use.

3.125 Any staff member, voluntary worker or committee member of a Voluntary Agency, Church or Community Organisation who has concerns that a child has suffered or is likely to suffer significant harm should:

- immediately consult with the leader or designated senior staff member
- report concerns to the Social Work Manager in the Trust's Family and Child Care Team (see appendices for useful contact numbers)
- keep a written record of concerns/suspicions
- attend Case Conferences and other meetings when invited.

Each Trust should ensure that appropriate members of staff are available to provide advice to the voluntary and community sector on Child Protection matters.

Other Departments and Agencies

3.126 Many other Departments and Agencies have direct and indirect responsibilities for children, such as:

- Northern Ireland Guardian Ad Litem Agency (NIGALA)
- Northern Ireland Housing Executive (NIHE) and Housing Associations
- The Northern Ireland Prison Service
- Private Agencies/Facilities
- District Councils
- Sporting Organisations
- Voluntary Organisations
- Public library services
- Museums

3.127 Regardless of their size or area of responsibility, all Departments and Agencies involved in work with children and families must be committed to ensuring that children are protected from harm. They must have child protection policy and procedures that are known by all staff and which do not conflict with these Procedures.

3.128 Everyone who has contact, directly or indirectly with children has a responsibility to protect them from harm. Within the workplace it is the responsibility of the individual concerned to report any concerns about child abuse to his Line Manager/Head of Department or Agency.

3.129 Child Protection concerns must be referred immediately to the Social Work Manager in the Trust's Family & Child care Team and followed up in writing within **24 hours.**

3.130 Any Department or Agency that identifies a conflict in adhering to these Procedures should draw the matter to the attention of their Senior Manager/Management Committee and, if necessary, to the attention of the ACPC.

3.131 Close collaboration and liaison between Adult Services and Children's Services are essential in the interests of children.

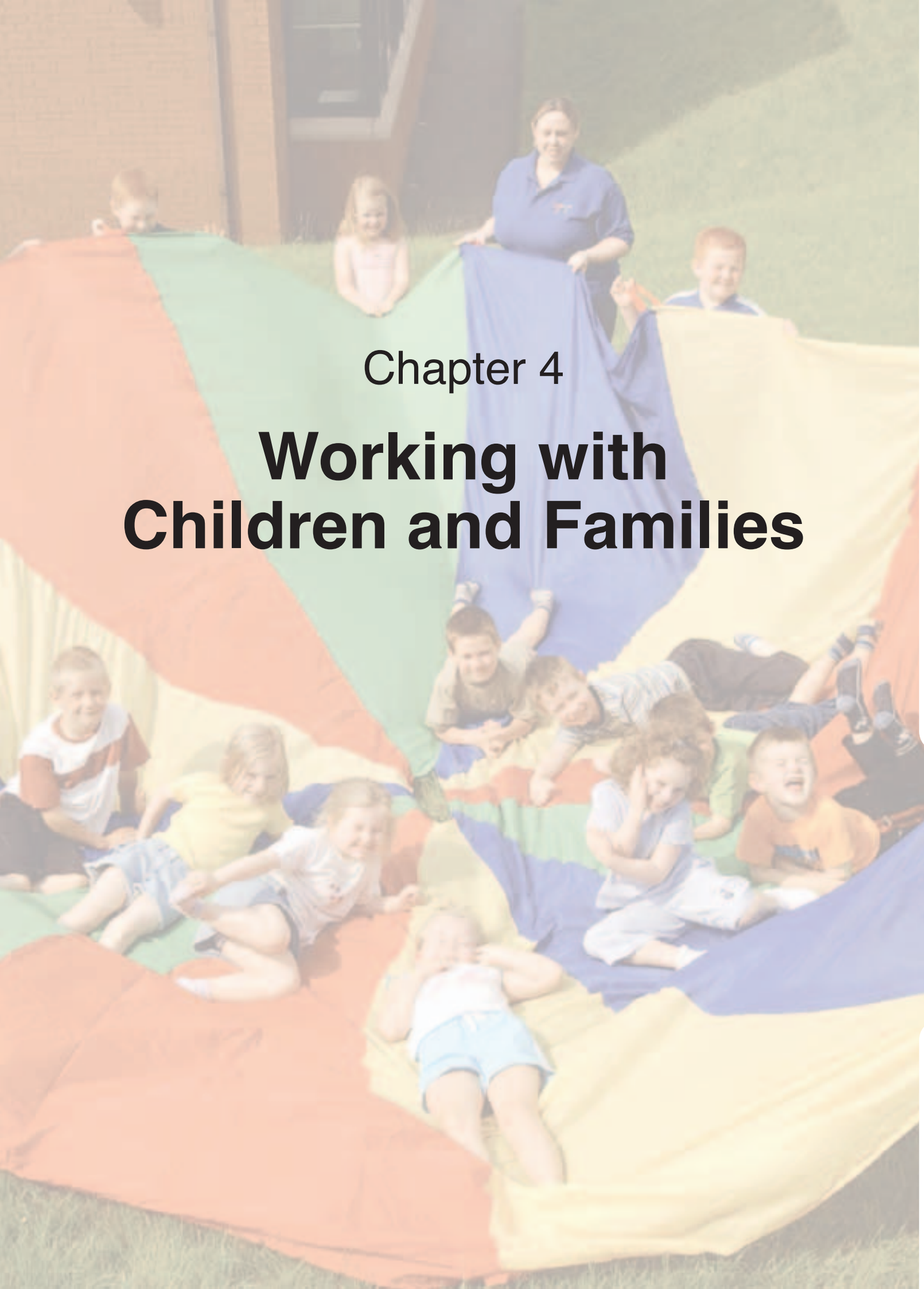
General Public

3.132 Members of the public in their day to day interactions with children and families may have suspicions/concerns about particular children or individuals in contact with children.

3.133 It is important that suspicions/concerns are not ignored but are shared with appropriate child care professionals so that, where necessary, action is taken to protect children from abuse.

Any member of the public concerned about a child who may be at risk of abuse should refer the matter to Social Services, NSPCC or Police. Details of the source of referral will normally be kept confidential when originating from a member of the public. However, an absolute guarantee of confidentiality cannot be given, as there may be occasions when the source of referral may have to be disclosed, for example, in Court.

3.134 HSS Boards and HSS Trusts will endeavour to work in partnership with the Public to promote public awareness about the child protection service with a view to ensuring that children are protected from harm.



Chapter 4

Working with Children and Families

CHAPTER 4 WORKING WITH CHILDREN AND FAMILIES

Policy

4.1 When working with children and families it is the policy of the Area Child Protection Committee to:

- ensure that services are child focused
- promote openness by professionals in their work with families in order to enhance the effectiveness of the child protection process
- ensure that families are informed and consulted about the process in a manner which is consistent with the safety and welfare of the child
- invite family members to Child Protection Case Conferences unless a decision is made to exclude a parent based on the criteria outlined in Chapter 6.

Principles

4.2 The principles of working in partnership with families to safeguard children are that:

- the needs and rights of children come first i.e. the safety and well being of each child are paramount
- those working together should share an understanding of how children and families will be involved at each stage of the child protection process and what information will be shared with them
- there should be openness and a willingness to listen to families in order to enhance the families' strengths
- there should be honesty with the family about each professional's role, responsibilities, duties and powers
- care should be taken not to infringe privacy any more than is necessary to safeguard the welfare of the child
- permission should be sought where practicable from the family before sharing confidential information with others on a 'need to know' basis

- account should be taken of the views of all those family members who have a significant role in the child's care and future safety
- where relationships between professionals and the family become non-productive in safeguarding the child, agencies should give consideration to a change of worker, providing this is in the best interests of the child.

Objectives

4.3 The objectives of working with the child and the family in the child protection process are to:

- explain the child protection process, including the powers, duties, roles and responsibilities of those concerned
- present clearly to families the concerns of others regarding their children in language that is easily understood
- seek the family views, concerns and perceptions of their needs and of support required
- enable family members to contribute to assessment, information-sharing and decision-making
- agree and clarify where appropriate, a protection plan to include the expectations of all concerned and the timescale involved;
- review and update such agreements with all concerned at regular intervals
- explain to family members their rights to appeal and how to appeal or make a complaint
- it may be deemed necessary or helpful to offer advocacy services to the family, in particular if the parents or main carers have difficulty due to disability in understanding professional concerns.

Involving Children and Families

4.4 Children need to understand the extent and nature of their involvement in decision-making and planning processes. They need careful preparation and support. They should be helped to understand:

- how the Child Protection Process works
- how they can be involved
- that their views will be taken into account.

They should understand that adults and professionals who know them are responsible for decisions taken about their future.

4.5 Family members have a unique role and importance in the lives of children. Family members have the right to know what has been said about them.

4.6 Family involvement should reflect the maximum degree of information-sharing and discussion with the family consistent with the safety and welfare of the child. The extent of the involvement, and its limitations, should be explicit and be clearly communicated to the family. Partnership with families does not mean always agreeing with them or always seeking a way forward which is acceptable to them.

4.7 Children should be fully informed of processes involving them, consistent with their age and understanding. Decisions about their future should take account of their views and wishes.

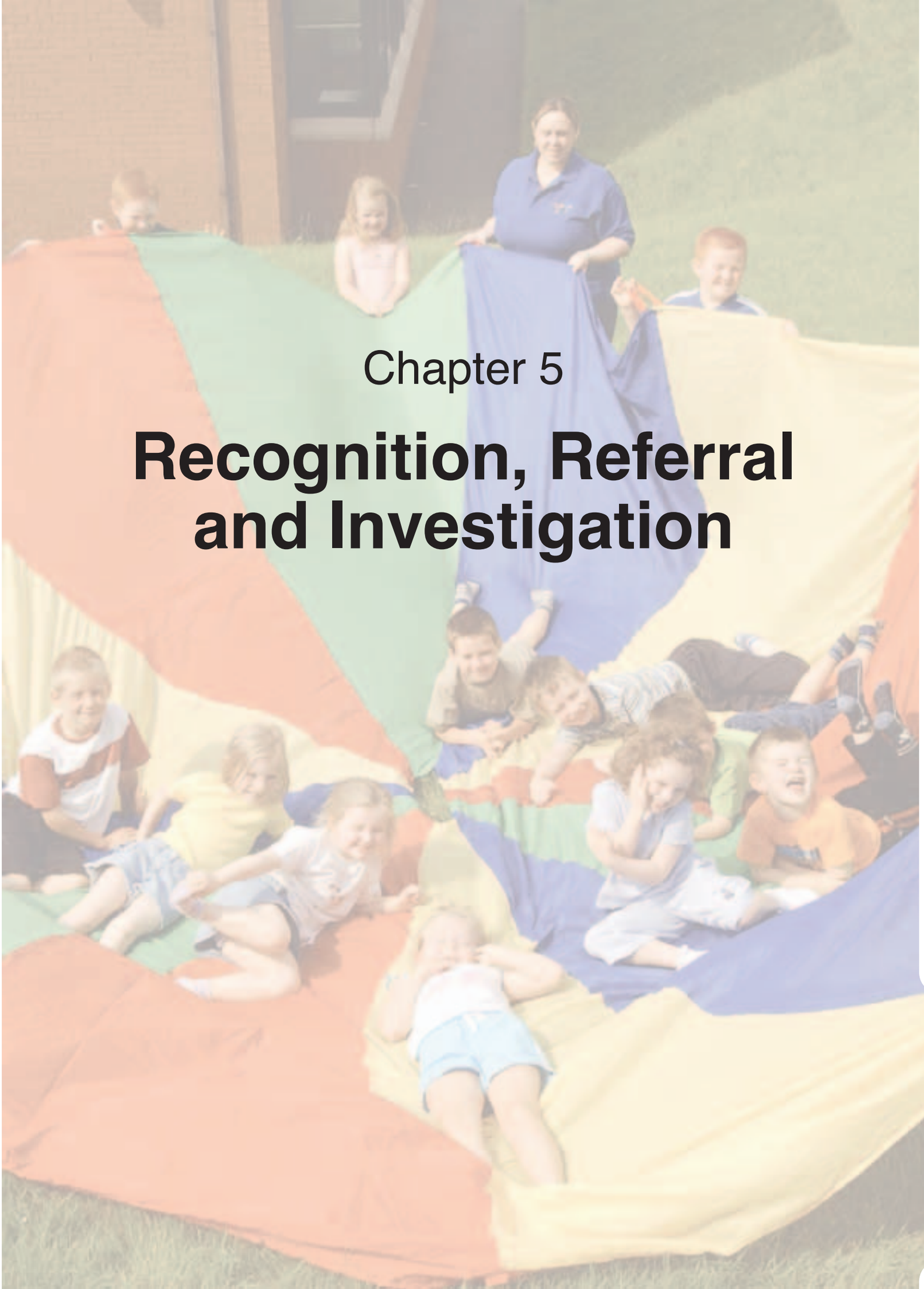
Family Group Conferences

4.8 Family Group Conferences are a process by which immediate and extended family members are enabled to meet together to find solutions to difficulties, which they or a child in their family are facing.

4.9 Family Group Conferences may be appropriate in a number of contexts where there is a plan or a decision to be made. They do not replace or remove the need for Child Protection Case Conferences, however, which should always be held when the criteria are met (see chapter 6).

Child Protection Process

4.10 The aim of the Child Protection Process is to ensure the safety and welfare of a child. Professionals must always maintain the focus on the child's needs. Where a conflict of interest occurs, the child's rights and needs will take precedence over those of his parents. The child's interest must always be paramount.

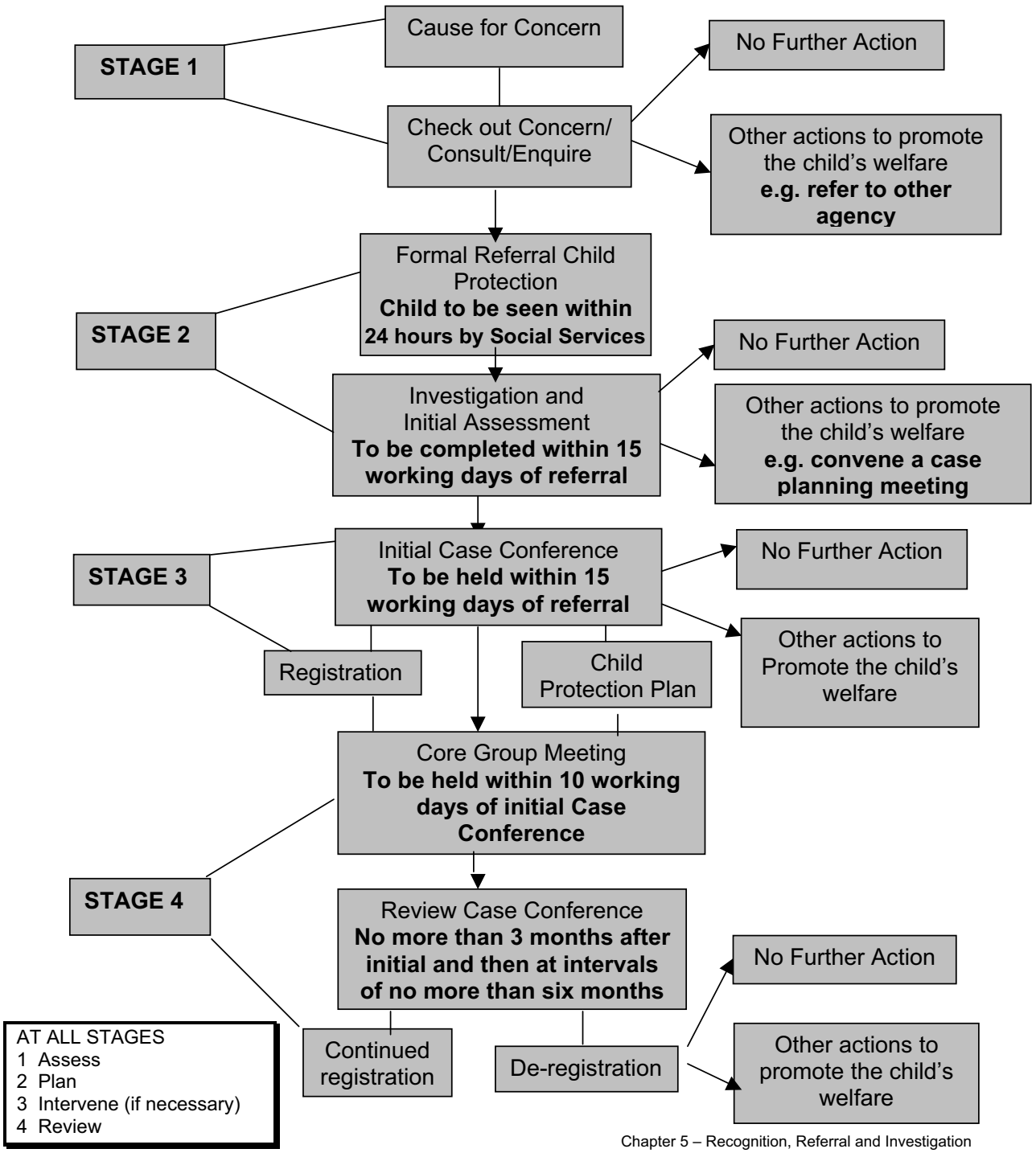


Chapter 5

Recognition, Referral and Investigation

CHAPTER 5 RECOGNITION, REFERRAL AND INVESTIGATION

5.1 This chapter provides guidance on the action which should be taken where there are concerns that a child has suffered, or is likely to suffer significant harm. The flow chart below highlights the key decision-making points in the multi-agency response to these concerns.



5.2 The decisions about how the case is managed at each stage of the Child Protection Process must be based upon assessment of the information obtained. Professionals making such decisions must do so on the basis of a multi-disciplinary sharing of information. Any action taken to intervene in the life of a child and his family must be based upon clear and sound reasons.

5.3 The reasoning behind the decisions and action must always be clearly evidenced and recorded in the child's case file.

Recognition

5.4 Everyone who works or has contact with children and families should be able to recognise, and know how to act upon, indicators that a child's welfare or safety may be at risk. They should know how to refer any such concerns to Social Services. Appendix 2 provides a list of some of the indicators which may be useful for referral purposes.

How to make a Referral

5.5 Any person who believes or suspects that a child is suffering, or is likely to suffer, significant harm should immediately inform the appropriate Health and Social Services Trust Child Care Team. There may be occasions when referrals to the NSPCC Investigative Service or the Police may be more appropriate.

5.6 In cases where professionals have concerns about a child but are not sure whether to make a referral, they should seek appropriate advice. They may consult the appropriate Social Services office and in these instances they should be explicit that they are requesting advice and consultation and that they are not making a referral. It must be recognised, however, that the process of consultation may identify a degree of risk that warrants making a referral.

If in doubt, every agency has the responsibility to consult or refer the child.

5.7 Arrangements about who makes the referral will vary amongst agencies. All agencies that are members of the ACPC should have their own policies and procedures on child protection, which acknowledge a responsibility to refer directly to Social Services when there are child protection concerns about a child.

Arrangements within an agency may be that a more senior member of staff is responsible for referral, but if this person is not available the individual member of staff retains a personal responsibility to ensure that suspicions of child abuse or neglect are reported without delay to Social Services.

5.8 Referrals during office hours are normally to a member of the appropriate Health and Social Services Trust Child Care Team. Outside office hours, urgent referrals should be made to the Social Services Out-of-Hours Services (see Appendix 3 for contact addresses and telephone numbers).

5.9 A referral should be made of any suspected abuse even where it is known that Social Services are currently involved with the family. If the name of the allocated social worker is known the referral should be made to that worker, or in his absence, to his line manager or duty social worker.

Parents Agreement to Making a Referral

5.10 Wherever possible, the parent's (or child's) agreement should be obtained before making a referral to another agency. In some circumstances, however, agreement may not be given but the protection of a child will require the referral to be made immediately.

5.11 If the concerns relate to the issues of chronic neglect observed over time this should be discussed with the parents before referral. They should be advised of the intention to refer the concerns to Social Services.

5.12 When no previous allegation of abuse has been made and an injury that may be accidental is observed on a child, it is appropriate for an explanation to be sought from a parent by the professional observing the injury. Any child who can communicate directly should be asked how the injury has occurred and the details recorded in the child's file/notes.

Information to be Provided When Making a Referral

5.13 A referral of child abuse to the HSS Trust can be made in person, by telephone or in writing but should be followed up in writing if not done so initially.

Referral Concerning a Child with a Disability

5.14 In addition to the details required for any referral, further information in relation to a child with a disability should be provided. Further guidance is given in Chapter 9.

Anonymous Referrals

5.15 Anonymous referrals from members of the public are accepted and treated as any other referral on the basis of the information provided. It should be impressed upon the referrer that to intervene effectively maximum information is required, including details of other witnesses or means of verifying information. The referrer should be advised that in some circumstances the subsequent enquiries may lead the person suspected of abuse to deduce who the referrer might be. The referrer should also be advised to make contact if further concerns arise.

Receiving a Referral

5.16 The person receiving a referral should clarify whether the nature of the concern indicates the possibility of significant harm and whether urgent action is needed to safeguard the child. Every effort should be made to obtain details of the identity of the referrer, his whereabouts, age etc., and his relationship with the child or children concerned, their family and the alleged abuser. The referrer may refuse to give details of his identity, and thus will be an anonymous referrer. Alternatively the referrer may give details of his identity but request that his identity is not disclosed. This is not an anonymous referral and referrers must be informed that while social services will endeavour not to disclose their identity this cannot be guaranteed particularly if a Court directs disclosure.

5.17 Good information taking is essential. Taking time to get all the information necessary can save the need to re-contact the referrer, which may not always be possible, e.g. in the case of anonymous referrals, and avoid gaps in information that could prove serious at a later stage. The person receiving the referral will:

- give his name and designation
- obtain the name, address and contact details of the referrer in full where the referrer is agreeable to providing this
- help the referrer to give as much information as possible

- clarify information that the referrer is reporting directly and information that has been obtained from a third party
- clarify who knows about the referral
- clarify the whereabouts of the child
- if necessary, explain the role of social services
- explain the process and timescales for social services initial assessment of the referral
- agree how to re-contact the referrer if further clarification is required
- clarify the extent to which the referrer's anonymity can be maintained, although this will relate only to members of the public
- remind professionals of service users' rights of access to files and that work is on a basis of shared information
- clarify expectations about how and when feedback needs to be given
- inform the referrer about who to contact and provide the relevant telephone number if they need to telephone again
- record the referral information received
- record date and time the referral was received
- record how the referral was received, e.g. by telephone, person, anonymous.

5.18 Difficulty in obtaining information, however, should not delay preliminary enquires, strategy discussion or seeing the child.

5.19 Any person making a referral of child abuse should be made aware that subsequent investigation might be conducted jointly by Police and Social Services and/or the NSPCC. The referrer and Social Services should be clear about:

- what action will be taken
- by whom
- within what timescale.

This should be recorded by Social Services and placed in the child's case file.

5.20 Professionals who make verbal or telephone referrals to Social Services should confirm them in writing within **24 hours**.

Confirming Referrals

5.21 The referral, and action agreed, including categorisation of referral, should be confirmed in writing by the Social Work Manager to the referrer within **5 working days** of the receipt of the referral.

5.22 Receipt of a referral from a member of the family or the public should also be acknowledged in writing within **5 working days**.

5.23 Should a professional, including Health Professionals, become aware that a professional assessment, opinion or diagnosis provided by him has been misinterpreted, then he has a duty to contact Social Services/other agencies directly in order to clarify his view. All corrections should be made in writing within **5 working days**.

Following Referral

5.24 After receiving a Child Protection referral the social worker should immediately check:

- the Child Protection Register
- Social Services' computerised and manual records
- with all agencies, including their own, that may have information about the child and family.

5.25 In the course of these initial enquiries every attempt should be made by the social worker to fill gaps in the referral information, record this fully and pass this to his line manager.

5.26 Where a referral is received outside normal office hours and is of a nature requiring an immediate response, these preliminary checks, apart from checking the Child Protection Register, may have to be undertaken during the following working day.

5.27 In arranging appropriate further action the Social Work Manager will:

- allocate the referral immediately to a suitably qualified and experienced social worker

- act to ensure the immediate protection of the child, including medical care, if necessary
- agree a contingency plan
- support, advise and supervise the social worker
- take account of all information to make decisions about further action
- arrange a strategy discussion under the Joint Protocol, if appropriate
- discuss with the appropriate Line Manager the need for a Child Protection Case Conference
- in conjunction with the social worker agree any decision to refer a child to other services/agencies
- ensure that the referral information is entered on the computer data system on the day of referral.

5.28 The child must be seen and spoken to within **24 hours** of Social Services receiving the referral where the referral information indicates significant harm to the child.

Opening of Case File

5.29 Following referral, the Social Work Manager should ensure that the appropriate file record is created in respect of each individual child within **24 hours**.

5.30 The Social Work Manager should read and agree the decisions and actions recorded and countersign and date the child's case file on an ongoing basis.

Strategy Discussion (Joint Protocol)

5.31 When Social Services, the NSPCC or Police, having taken into consideration other professional opinions, are satisfied that there are sufficient grounds to warrant joint investigation, contact between managers in the Police and either Social Services (or the NSPCC if they have received the referral) should be made immediately. A strategy discussion should take place to plan the investigation in accordance with the "Protocol for Joint Investigation by Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse" (Joint Protocol). This need not necessarily involve a meeting and could be conducted by telephone.

5.32 In the strategy discussion agencies will agree whether a single or joint investigation is necessary. The purpose of the strategy discussion should be to share available information and to agree what action, if any, will be taken within **24 hours**. The strategy discussion must be recorded in writing by the Social Services'/ NSPCC's representative and forwarded to all those attending the meeting within **5 working days**. This section should be read in conjunction with the Joint Protocol.

Gaining Access to Children

5.33 All professionals must have official photographic identification to show to parents and children A responsible parent will refuse access to a child where an adult cannot prove his identity. It is appreciated that access to a child will not always occur in the presence of a parent, for example, contact may take place in a hospital setting and therefore professionals should carry photographic identification.

5.34 If access to the child is refused following negotiation, consideration should be given to the appropriateness of a Child Assessment Order (CAO)or Emergency Protection Order (EPO). Legal advice should be sought before applying for either Order, and consideration given to the qualifications in Article 8 ECHR.

INVESTIGATIONS

Initial Assessment Following Allocation

5.35 The Initial Assessment to determine the need of and risks to the child may be completed in 2 stages, the first of which should be within **7 working days** of referral and an initial plan developed. Where a possible risk to the child is identified the second stage of the assessment should be completed within **15 working days** from the day of the referral

5.36 The assessment and any subsequent actions and decisions should be recorded in the child's file and countersigned by the Social Work Manager. The Manager should be involved in any decision to refer a child to another service or agency.

If at any stage during the initial assessment there is reasonable cause to suspect that the child is suffering or likely to suffer significant harm, inquiries under Article 66 of the Children Order must be initiated.

Immediate Protection

5.37 In the majority of cases immediate protection will not be necessary. If the child is assessed as not to be at risk of immediate harm it will be possible to plan the investigation in line with the Joint Protocol whilst ensuring the child is adequately protected.

5.38 Where a child is deemed to be in need of immediate protection consideration should always be given to the least intrusive form of intervention provided that the child is not left at risk of significant harm. For example, under the Family Homes and Domestic Violence (NI) Order 1998 consideration can be given to a parent applying for an Exclusion Order to exclude an adult who poses a risk to a child from the family home, and a Non-Molestation Order to protect the child from the alleged perpetrator. Whilst these legal remedies obviate the need for the child to leave the family home or to be separated from the rest of their family, such provisions should only be relied upon if the parent or person caring for the child is deemed suitable to adhere to the terms of such Court Orders and ensure that the alleged perpetrator does not breach the Order, for example, by returning to the family home, or having unauthorised contact with the child.

5.39 If Social Services, the Police or the NSPCC receive a referral which indicates that a child's risk of suffering significant harm cannot be prevented by voluntary measures in co-operation with the family, they should secure the immediate safety of the child by:

a) applying to the court for an Emergency Protection Order or Interim Care Order (either of which can include a provision to exclude contact between a child and a specified adult) and ensuring the child is in a safe place; or

b) in exceptional circumstances, Police protection where the child could not be protected by any other means (Article 65).

5.40 When taking emergency action, the need to safeguard other children in the same household or the house of the alleged perpetrator should always be considered.

5.41 Legal advice should be sought before taking action to remove a child from his family. The Trust Director of Social Services (or his nominee), senior Social Work Manager or an NSPCC's Area Children's Services Manager (ACSM) or Out-of-Hours Co-ordinator

must authorise any immediate protective action necessary to protect the child that is taken without legal advice. The reasons for these actions must be recorded on the child's file and signed by the manager making the decision.

5.42 Planned emergency action will normally take place following a strategy discussion. Where a single agency has to act immediately to protect a child, however, a strategy discussion should take place within **24 hours**.

5.43 In some cases it may be possible to secure a child's safety by:

- a parent taking action to remove an alleged perpetrator
- the alleged perpetrator agreeing to leave the home rather than enforcing the emergency action outlined above
- preventing an alleged perpetrator from returning to the home.

5.44 In some instances a child may be found to be at risk in an HSS Trust area where he is not normally resident, or the child's area of normal residence is unclear. In these circumstances the responsibility to ensure that immediate protective action is taken rests with the Trust in whose area the child is present at the time he needs immediate protection.

5.45 If the child is "looked after" by another HSS Trust or Authority[8], or is on the Child Protection Register of another HSS Trust or Authority, the HSS Trust in whose area the child is located should involve the HSS Trust or Authority responsible for the child. The HSS Trust or Authority responsible for the child has the duty to take appropriate protective action.

There should be no delay in ensuring that appropriate emergency action is taken.

Case Planning

5.46 The outcome of the initial assessment may be that the child is not at risk of significant harm, or has suffered significant harm but is not at continuing risk. In these circumstances consideration should always be given to the child's and the family's need for support or services. In this context a Case Planning Meeting involving the family and other key professionals should be considered.

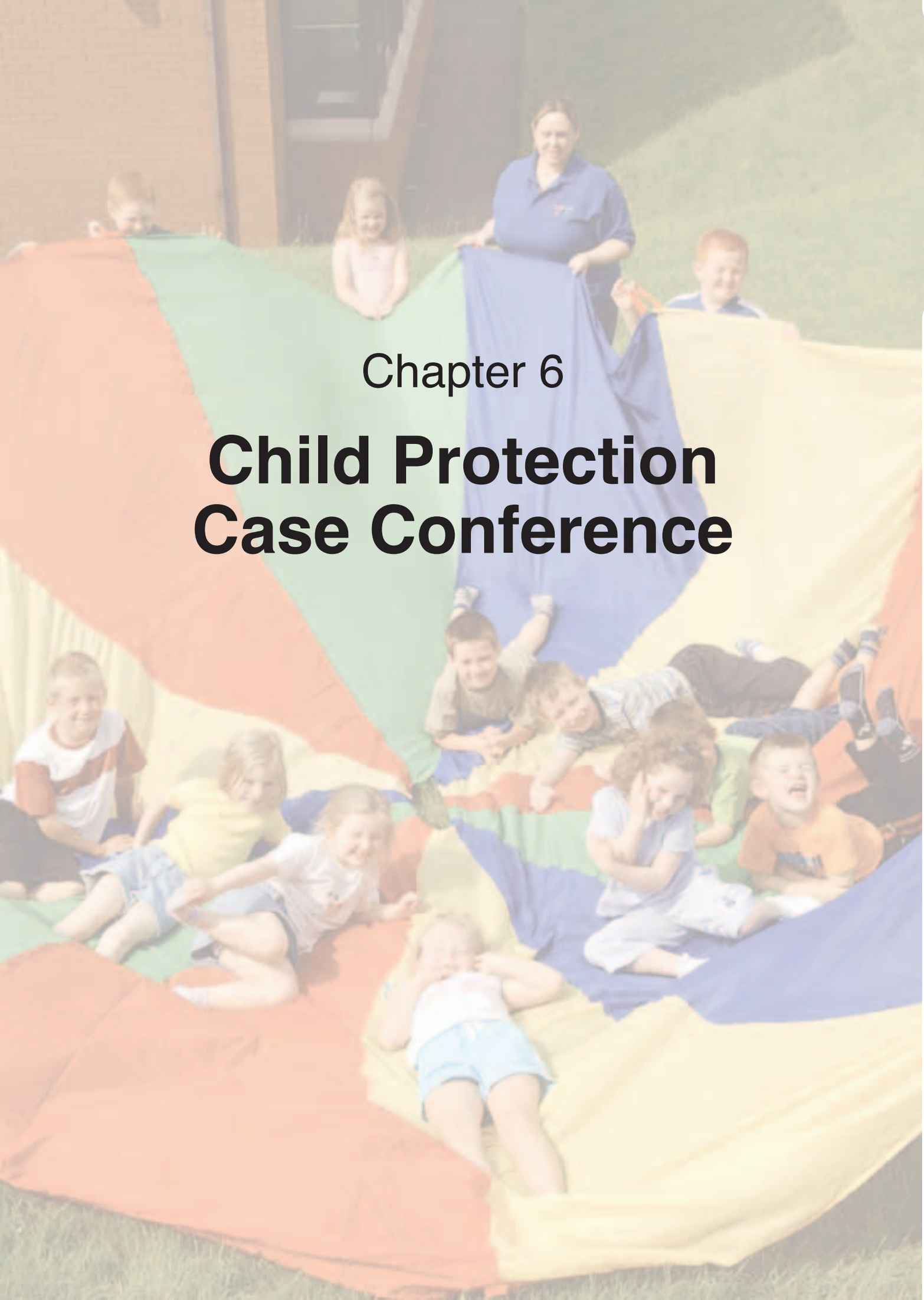
5.47 The Social Work Manager in the Family and Child Care Team

8 "Authority" relates to a social series department in England, Scotland, Wales or the Republic of Ireland

should always give consideration to the need for a Case Planning Meeting where there are multiple referrals (i.e. more than one) about a particular child or his family, even if an initial assessment indicates that the child has not suffered significant harm or is not at continuing risk.

5.48 The purpose of such a Case Planning Meeting is to ensure that all key professionals share information about their role with the family, their assessment of the need for support or services for the family and the nature of the referrals made about the child.

5.49 Further guidance is contained within each HSS Boards/HSS Trusts local policy and procedures on family support and children in need.



Chapter 6

Child Protection Case Conference

CHAPTER 6 CHILD PROTECTION CASE CONFERENCES

6.1 The Child Protection Case Conference (Case Conference) is central to the Child Protection Process. It is a multi-disciplinary/multi-agency meeting that brings together the family and professionals concerned with child protection and provides them with an opportunity to exchange information and plan together.

6.2 With the exception of decisions on registration and de-registration, it is not an executive body. The results of the discussion are recommendations to individual agencies for action. The decision to implement the recommendations must rest with the individual agency concerned. Nevertheless, it is expected that individual agencies attending Case Conferences would commit themselves to a course of action which is within their authority. Any deviation from the recommendations should not be made, except in an emergency, without informing the other agencies involved, through the Chairperson.

Criteria for Convening an Initial Case Conference

6.3 An Initial Child Protection Case Conference will be convened in the following circumstances:

- where the concerns are substantiated after a child protection investigation and the child is assessed to be at continuing risk of significant harm
- following information that a child is in regular contact with an adult who has been convicted of a Schedule One[9] offence against children and who is considered to be a risk
- following information that a child is in regular contact with an adult who has been suspected of previous incidents of child abuse and it is deemed that the child may be at risk of significant harm
- where a young person has abused another child and there is evidence that the young person committing the abuse is at risk of significant harm or has been abused

[9] Schedule One of the Children and Young Persons Act (NI) 1968 details a range of sexual and non sexual offences committed against children.

- when a child moves into, or is born into, a household where a child's name is currently on the Child Protection Register, or a child died or has been seriously injured as a result of suspected abuse
- when consideration is being given to a child's return to the community from a 'looked after' placement or period in hospital and his name was on the Register immediately prior to being looked after or admitted to hospital
- where a woman is pregnant and there is a need to consider serious potential risk to the unborn child and plan protective action prior to the birth of the child. If a decision is made to register the unborn child, this will come into effect at the birth of the child
- when a child from another Trust or Authority's Child Protection Register moves into the Trust's area.

Convening of a Case Conference

6.4 A Case Conference should be convened by the HSS Trust, or the NSPCC if they have responsibility for the case, when it is clear either during or following an investigation that a decision has to be made on whether or not to place the child's name on the Child Protection Register.

6.5 Senior managers of HSS Trust staff (Family and Child Care Programme) are designated to act as conveners and Chairpersons of Child Protection Case Conferences, as Social Services have a lead role in the protection of children and manage the Child Protection Register.

6.6 Any agency may request an initial Case Conference by contacting the appropriate Social Work Manager (APSW equilivent or above) who will normally comply with such a request where the circumstances of the case appear to meet the criteria for convening an Initial Child Protection Case Conference. Should the Social Work Manager (APSW equilivent or above) decide not to arrange a Case Conference he should respond in writing to the Agency concerned stating the reasons.

Functions of an Initial Child Protection Case Conference

6.7 The Initial Child Protection Case Conference brings together the family members and professionals from the agencies that work with children and have child protection responsibilities to:

- share and evaluate the information gathered during the investigation
- assess whether the child is at risk of significant harm (a risk analysis model must be applied in the Initial Case Conference to assist the decision-making process on whether to register or not)
- decide on the need for registration
- agree an inter-agency child protection plan for the future needs of the child if the child's name is placed on the Child Protection Register. This should include supportive services to the child and the family
- agree a review date within **3 months** if the child's name is placed on the Child Protection Register
- agree the arrangements for the completion of a comprehensive assessment
- consider the provision of family support services if the child's name is not placed on the Child Protection Register.

Risk Analysis

6.8 The purpose of a risk analysis is to assist in the structuring of multi-agency decision making. It is designed to help clarify the issues in relation to the protection of the child, to address the key questions in decision-making in situations where risk is present including what is the problem and how serious it is. This should allow the range of professionals and those caring for the child to be clearer about what they were worried about and how worried they are that abuse or neglect will continue or reoccur.

Timing

6.9 The timing of an Initial Child Protection Case Conference will depend on the urgency of the case and on the time needed to obtain relevant information about the child and family. If the conference is to reach well informed evidence-based decisions it

should take place following adequate assessment. At the same time cases where children are at risk of significant harm should not be allowed to drift. Consequently all Initial Child Protection Case Conferences should take place within **15 working days** of the first referral. If this is not possible, the HSS Trust's Director of Social Work (or his nominee) should approve the grounds for this delay. The reason for the delay should be recorded on the child's case file and in the minutes of the Case Conference.

Pre-birth Child Protection Case Conference

6.10 A pre-birth Child Protection Case Conference should be requested as soon as it is apparent that a child when born may be at risk of significant harm (but not before the 24th week of the pregnancy) if:

- the expectant mother is living with, or in contact with, a person who is known to have abused or neglected children
- the expectant mother has abused or neglected children
- the lifestyle of the expectant mother or other potential carer is/are such that the child may be at risk following the birth
- there are concerns about potential parenting capacity.

6.11 The purpose is to plan co-ordinated action and services for the protection of the child at the time of birth based on the pre-birth risk assessment. The conference can decide to place the child's name on the Child Protection Register when born and formulate a Child Protection Plan without a further conference. A review Case Conference should be held within **3 months** of the initial pre-birth Case Conference.

6.12 The pre-birth Child Protection Case Conference will be conducted in the same way as the Initial Child Protection Case Conference. In addition to membership of the Case Conference as identified in Section 6.19, midwives (hospital and community), the obstetrician and the health visitor should also be invited.

6.13 The Chair of the Case Conference should ensure that all those invited to the pre-birth Case Conference are notified of the birth and addition of the child's name to the Child Protection Register.

Venues for Case Conferences

6.14 The convenor of the Case Conference should arrange the date, time and venue of the Case Conference for the convenience of the majority of the participants, but pay particular attention to accessibility for the parent and/or child. Where any participant has a disability or other special needs, particular consideration will have to be given to the suitability of the venue in terms of physical access and the availability of any necessary supports.

Chairing Child Protection Case Conferences

6.15 A Case Conference must be chaired by a senior member of Social Services staff, that is Social Work Manager (APSW equilivent or above) or the NSPCC Area Children's Services Manager (ACSM) where appropriate. The Chairperson should have knowledge and expertise in child protection, and skills in chairing Case Conferences.

The main responsibilities of the Chairperson are to ensure that:

- the Case Conference maintains a focus on the child, whose interests are paramount
- the purpose of the Case Conference is clear
- members of the Case Conference understand the confidential nature of the information being discussed
- all relevant people, including parent or child, are present and are able to fully contribute to the Case Conference
- written reports are considered by the Case Conference
- the Case Conference takes the necessary decisions
- parents and where appropriate the child, are made aware of the decisions to place a child's name on the Child Protection Register and the purpose of the Register
- membership of the core group is identified
- a written minute is taken of the Case Conference which records those participating, apologies, absentees, brief details of the discussion, the decision and recommendations, and its circulation agreed

- the decision to place a child's name on the Child Protection Register is recorded on the child's file and the Child Protection Register within **24 hours** of the Case Conference.

Attendance at a Case Conference

6.16 The Case Conference should consist of the relevant number of people conducive to achieving its purpose but must be quorate. Those attending Case Conferences should be there because they have a significant contribution to make, arising from professional expertise and/or knowledge of the child and family. There should be sufficient information and expertise available, through personal representation and written reports, to enable the Case Conference to make an informed decision about what action is needed to safeguard the child and promote his welfare and to make realistic and workable proposals for taking that action forward.

6.17 A Case Conference may be large in the early stages of work when a number of agencies may be contributing to the investigation, the assessment or case planning. Once a long-term plan has been formulated a smaller group of key workers from the agencies involved in the child protection plan, including the case co-ordinator, should be identified as the core group who will work together to implement and review the plan.

6.18 Attendance at Case Conferences for such purposes as maintaining an overview of child protection work or supervising, managing or monitoring an agency's subsequent input into the case should be discouraged. Supervisors may need to accompany inexperienced workers, however.

6.19 The following persons should always be invited to the Initial Case Conference, as appropriate:

- Parents
- Child or young person
- Social Worker, Family and Child Care
- Senior Social Worker/Team Leader, Family and Child Care Team
- Police Officer, CARE Unit/ Domestic Violence Officer
- Health Visitor and/or School Nurse

- Named Nurse for Child Protection
- GP
- Named Paediatrician for Child Protection
- School Principal/Designated Teacher and/or class teacher in the case of a school-age child
- Education Welfare Officer in the case of a child of school age.

6.20 Other personnel may need to be invited, as appropriate, e.g.

- Social Workers from other programmes of care
- Trust Legal Advisor
- Consultant Psychiatrist
- Forensic Medical Officer
- Hospital Medical, Nursing and Social Work Staff
- Adult Mental Health, Medical, Nursing and Social Work staff
- Child and Adolescent Mental Health, Medical, Nursing and Social Work staff
- Allied Health Professionals
- Probation Officer and/or Prison Officer
- Youth Justice Agency Staff
- Representative of the Armed Services in cases where there is a service connection
- Relevant voluntary organisations
- Relevant foster carers
- Guardian ad Litem.

6.21 An agency wishing an observer to attend must contact the chair of the Case Conference at least **3 working days** prior to the Case Conference. There will not be more than one observer in attendance at any one Case Conference. The social worker will be responsible for asking the parent/child to give his permission for an observer to attend in advance of the Case Conference and his response given to the Chair.

6.22 An observer will be permitted to attend a Case Conference if he is a student on placement with agencies which have involvement in Child Protection.

Quorum

6.23 Whilst it is inappropriate to fix a number for attendance at Case Conferences, it is important that those attending are able to contribute from their knowledge of the child and family. Decisions to register the child should not be taken where the main professional referrer or his representative is not present. Ideally, substitutes should not be used except in exceptional circumstances.

6.24 To be a valid Case Conference there should be, in addition to the Chairperson, representation from Social Services and at least **two other agencies or disciplines** with knowledge of or direct contact with the child. Those not able to attend must provide reports that outline their assessment of the family situation.

6.25 This quorum may be breached if, under exceptional circumstances and with very short notice, an agency representative is unable to attend but has submitted a written report. The chair of the Case Conference will be responsible for deciding, in the best interest of the child, to proceed with a Case Conference if the quorum of Social Services and two other agencies or disciplines are not present, or not to proceed, despite being quorate, if the absence of critical information from any agency or professional could invalidate any Case Conference decision.

6.26 If the Case Conference cannot proceed those present must agree an Interim Child Protection Plan to ensure that the child is protected and another date for the Case Conference must be arranged within **10 working days**. The decision and reason not to proceed must be recorded in the child's case file and in the minutes of the reconvened Case Conference. A decision to place a child's name on the Child Protection Register cannot be made in these situations.

Involvement of Family and Child in the Case Conference

6.27 There is an underlying principle that parents should be involved in all of the discussions and decision making about their child. This accords with Article 6 (Right to a Fair Trial) and Article 8 (Right to Private and Family Life) of the ECHR. Separate attendance should

be considered, however, where a conflict between the family members, for example child and parents or estranged parents, would severely disrupt the Case Conference and prevent it from focusing on the protection of the child.

6.28 The social worker should advise the family that they will be invited to attend all or part of the Case Conference, subject to the Chairperson's decision about whether this might prejudice the interest of the child.

6.29 Whether or not they attend, the family should be encouraged to record their contribution in writing, or by other means, for the Case Conference.

6.30 A child and young person should be permitted to attend depending on his age, understanding and level of maturity and if he wishes, bring a friend or someone to support him. Any child who chooses to attend should be prepared by the social worker. The use of appropriate literature is recommended. If a child does not wish to attend, the social worker should enable him to submit his views in writing or by other means to the Case Conference.

6.31 If the family encounter difficulties, for example with child care, travel or finding a support person, every possible assistance should be given in order to facilitate their attendance.

6.32 Where difficulties arise, e.g. because of physical disability or sensory impairments, arrangements to facilitate attendance at the Case Conference should be made. Consideration should be given to the appropriate means of communication, e.g. interpreters.

6.33 The family should be invited to arrive at the Case Conference venue at least **fifteen minutes** before the start to allow the Chairperson to advise them of the Case Conference process, who will be present and their right to appeal against the decision of the Case Conference. The Chairperson will take responsibility for introductions between the family and members of the Case Conference ensuring that the family are made aware of the professional roles of all participants and of the reason for their attendance.

6.34 Family members should have the opportunity to say whether or not they agree that there is a concern. This can be done in a variety of ways, e.g. verbally by them or by a support person, a social worker

on their behalf or by the Chairperson reading aloud their written contribution or by a combination of these.

6.35 While this policy will be appropriate in the majority of cases, it may have to be modified on occasions where this is required by particular circumstances, e.g. criminal investigations.

6.36 The Chairperson of the Case Conference will ensure that the family is advised of its outcome in writing within **14 working days**. This will include the key elements of the Child Protection Plan if a decision has been made to place the child's name on the Child Protection Register.

Involvement of Alleged Abusers

6.37 In the interests of natural justice, the alleged abuser must be informed about the allegation and he and/or his representative given the opportunity either to attend the Case Conference in its entirety or part, or make representation in writing.

6.38 In R v Norfolk County Council Judge Wade held that a Case Conference had acted unfairly and in breach of natural justice by denying the alleged abuser the opportunity of being heard (Norfolk County Council ex parte M (1989) 3WLR 502). See section 7.4 of 'Co-operating to Safeguard Children' for further information.

6.39 The Case Conference focus is on the child and a decision to invite an alleged abuser to it must take into account the wishes and feelings of the child, among other things, having regard to age and understanding.

6.40 Each case must be considered on its own merit and social work staff must balance their statutory duty to protect a child from abuse against their duty of fairness to the suspected abuser.

Where there is conflict or disagreement in interests the interests of the child must remain paramount.

6.41 The possibility of false or malicious accusations should be kept in mind. The outcome of the Case Conference should be shared in writing with the alleged abuser in so far as it relates to him.

Exclusion from Child Protection Case Conferences

6.42 Parents, and children where appropriate, should be invited to attend the whole of the Case Conference. It is recognised, however, that there may be occasions when partial or total exclusion from the Case Conference is necessary. The decision to exclude a parent or child from a Case Conference rests with the Chairperson. Where a professional member of a Case Conference has concerns about sharing confidential information or discussing sensitive issues with parents present, this should be brought to the attention of the Chairperson prior to the Case Conference.

6.43 Those parents who are excluded should be advised that they have the right to make representation to the Case Conference by other methods, e.g. by letter, tape recording or representation on their behalf by a social worker or other professional.

6.44 The Chairperson will ensure that the parent is informed in writing of the exclusion and the reason. He will also ensure that the decision is recorded in the child's case file and the Case Conference minutes.

6.45 The attendance of parents and children is to facilitate openness, partnership and co-operation. It must be noted that their presence should not prevent or seriously disrupt the Case Conference from carrying out its primary task. If the Case Conference is being seriously disrupted, it is the responsibility of the Chairperson to take any necessary action. This may include temporarily suspending it or even postponement to a later date.

Where the family is not invited or not permitted to stay for the whole Case Conference, they will be seen afterwards in order to be informed of the conclusions, decisions and recommendations by the Chairperson and other appropriate members of the Case Conference. Where members of the family are excluded from all or part of the Case Conference, the reasons should be recorded in the minutes of the Case Conference and the child's file.

a) Partial Exclusion

6.46 Partial exclusion may occur at the discretion of the Chairperson in order to allow the conference to:

- receive confidential information about a third party

- hear the views of one parent separately from the other parent
- enable the child to express his views separately from a parent(s)
- enable professionals to discuss the issue of registration where third party information is being used to make this decision
- allow the Police to share information about a current criminal investigation.

b) Total Exclusion

6.47 In a minority of cases it may be necessary to exclude a parent from all of the Case Conference. This is a significant deviation from established principles and should apply only in exceptional circumstances when one of the following criteria applies:

- where there is evidence that the Case Conference will be seriously disrupted by the presence of a parent(s) to the extent that the meeting will not be effective
- where parental presence will create difficulties with police investigations or criminal proceedings
- where conflict between parents, or parent(s) and child, makes it impossible for all to attend
- where a parent(s) is believed to be under the influence of alcohol or drugs
- where a parent(s) suffers from mental health difficulties which in the opinion of a mental health professional make it inadvisable for him to participate in the Case Conference.

Attendance of Friends or Supporters

6.48 A parent and child must each be advised of his right to have a friend or supporter present at a Case Conference in order to assist him with full participation.

6.49 The role of the friend or supporter is to speak on behalf of the parent or child, having ascertained his view in advance of the meeting. The friend or supporter is not there to promote his own view. The Chairperson of the Case Conference must be informed prior to the Case Conference of the intention of the parent to bring a friend or supporter.

It is not the place of the friend or supporter to attend the Case Conference in place of the parent or child, and a request for a friend or supporter to attend in the absence of a parent will normally be refused.

6.50 In exceptional circumstances the Chairperson may prevent a friend or supporter from attending a conference, e.g. where a person has a conviction, or has been cautioned for certain Schedule One offences. A supporter may also be required to leave the conference if the Chairperson deems his presence to be disruptive.

6.51 The friend or supporter will not receive a copy of the Case Conference minutes.

Information for the Conference

6.52 The investigating social worker should prepare a written report for the conference in chronological case order. This should summarise and analyse the information obtained in the course of the initial assessment. The report should be factual, concise and provide all relevant information. Jargon and subjective comments should be avoided except where an analysis of the facts are presented as an assessment by the social worker.

6.53 The report must include

- factual detail about the family, e.g. names, dates of births, address(es), schools, GP, legal status, a geneogram of the family, extended family and the household
- a chronology of recent and historically significant events, agency and professional contact with the child and family
- details of the concerns that have led to consideration of the need for a child protection plan
- information on the child's current and past state of health and development
- information on the capacity of the parents and other family members to ensure the child's safety from harm
- the expressed views, wishes and feelings of the child, parents, and other family members
- analysis of the implications of the information obtained and any risks for the child's future safety

- recommendations for the Child Protection Plan.

6.54 The social worker must provide a parent, and child where relevant, with a copy of the report at least **one working day** prior to the Case Conference. The report should be explained and discussed with the family in advance of the conference. The parent's and child's agreement or disagreement should be recorded in the minutes.

6.55 Other professionals invited to attend the conference must provide a written report summarising the details of their involvement with the family and relevant information at least **one working day** prior to the Case Conference. Consideration should be given to the following areas were appropriate:

- the child's health and development, and developmental needs
- the child's educational development needs
- family and environmental factors
- the capacity of the parents to safeguard the child.

6.56 All agencies should endeavour to share the contents of the reports with all members, including parents, prior to the Case Conference. If an agency has concerns about the confidential nature of the reports or believes that information in them could prejudice continuing criminal investigations this should be discussed with the Chairperson and agreement reached about what may be shared.

6.57 All those providing information must take care to distinguish among fact, observation, allegation and opinion. Reports should highlight strengths as well as concerns and avoid jargon and unnecessary detail. Opinions and interpretations are important but must be evidenced.

6.58 Ideally, reports should be with the Chairperson **two working days** in advance of the Case Conference.

6.59 There is an expectation of strict confidentiality and the Chairperson must emphasise to participants that information exchanged at the Case Conference should not be disclosed or discussed outside the Case Conference unless it is necessary in the interests of the child. Any information received at the Case Conference for the purpose of child protection should not be used for any other purpose. The

exception to this is in relation to the police if information becomes available that suggests the possible commission of a crime.

Case Conference Agenda

6.60 The Chairperson is responsible for ensuring a systematic and ordered approach to the Case Conference. The Case Conference should be conducted in the following stages:

- Introductions
- Explanation of the Case Conference process
- Sharing of information relevant to the function of the conference
- Analysis of the information shared
- Conclusion
- Decisions
- Recommendations and action plan.

Decisions and Actions for the Case Conference

6.61 The Case Conference should consider if the child is at continuing risk of significant harm. The test to be applied is whether future significant harm is likely (see Chapter 2). This decision should be based on all available evidence obtained through existing records, the initial assessment and from inquiries and research. It should take into account the views of all agencies attending the Case Conference and any written contributions.

6.62 Every effort should be made to reach mutually agreed decisions, recommendations and action. Where there is a lack of consensus a majority decision should be taken with the Chair having the casting vote. The decision of the Case Conference and the reasons for it must be recorded in the minutes of the meeting.

6.63 It is recognised that each agency must retain the right to act independently within its own agency policy. Dissenting views on the child protection plan should be recorded in the minutes. Once decisions have been made each agency is expected to support and carry out the Child Protection Plan. Every effort should be made to establish the Child Protection Plan as a formal contract involving professionals, the family and the child.

6.64 The Case Conference must decide that either:

- the child is not at continuing risk and therefore the child's name will not be placed on the Child Protection Register. He may be in need of help to promote his health or development, however. In these circumstances the Case Conference should ensure that arrangements are in place to consider with the family what further help and support may be offered. The child should be assessed as a child in need, or
- the child is at continuing risk and therefore his name should be placed on the Child Protection Register. The act of registration itself confers no protection on a child and must be accompanied by a child protection plan. The Case Conference should determine under which category of abuse the child's name must be registered. (See section 7.7 for registration categories). The category used in registration will indicate to those consulting the register the primary presenting concerns at the time of registration.

6.65 It is the responsibility of the Case Conference to consider and make recommendation on how agencies, professionals and family should work together to ensure that the child will be safeguarded from future harm. This should enable professionals and the family to understand exactly what is expected of them and what they can expect of others. Specific tasks will include the following:

- appoint a case co-ordinator
- establish the key elements of the Child Protection Plan
- identify the membership of the core group and agree the date of its first meeting which must be held within **10 working days** of the Case Conference
- establish if, and how, the child, parents and wider family members should be involved in the process
- establish dates for completion of the Child Protection Plan by the Core Group
- identify what further specialist assessments of the child and family are required
- consider the need for a contingency plan if circumstances change quickly

- consider the circumstances in which it might be necessary to call a review Case Conference before the next review date
- agree a review date within **3 months**
- agree who should be informed that the child's name has been placed on the Child Protection Register.

Keeping Parents and the Child Informed

6.66 When a child's name is placed on the Child Protection Register the Chairperson of the Case Conference and the social worker should ensure that the parents and the child, if he is old enough, understand:

- the reason for the decision
- how registration and the Child Protection Plan are linked
- the procedure for de-registration
- where responsibility for decision-making lies
- the appeals process and the complaints procedure
- the procedure with regard to regular review of the child's progress and assessed risk.

6.67 The decision not to place a child's name on the Rregister must be confirmed in writing to the parents by the Chairperson within **14 working days** of the Case Conference.

Case Conference Minutes

6.68 Health and Social Services Trusts are responsible for ensuring that all Case Conferences they have convened have a dedicated person trained to take notes and produce minutes of the Case Conference for approval by the Chairperson. Where the NSPCC convene and chair a Case Conference, they will be responsible for producing the minutes.

6.69 The Case Conference minutes will include:

- a list of those present, apologies and those who did not attend
- the family composition
- the legal status of children (if appropriate)

- a record of any delay in convening the Case Conference and the reasons
- a record of whether the parents were excluded, either totally or partially, and the reasons
- a record of written reports submitted to the Case Conference
- the essential facts of the case with information about each child
- a summary of the discussion
- identification of the family's strengths
- a summary of the assessment of risk and needs of each child
- the decision on registration and the reasons for the decision
- the name(s) and designation(s) of anyone dissenting from the decision regarding registration and the reasons why
- the outline child protection plan
- the names of the case co-ordinator and the core group
- if the child's name is placed on the Child Protection Register, the category for registration and the date of the review Case Conference.

6.70 The Case Conference minutes are provided to each person invited to attend the Case Conference, except where they have stated that they have no current or planned involvement with the family.

6.71 The minutes will be distributed within **14 working days** by the Chairperson. Recipients are required within **7 working days** to confirm receipt of the minutes through returning the tear off slip provided. The minutes will be considered to be an accurate record of the meeting, unless objections are received by the Chairperson within **7 working days** of receipt of the minutes.

6.72 The minutes of the Case Conference are confidential and should not be shared with a third party without the consent of the Chairperson. In cases of criminal proceedings, however, the Police are empowered to reveal the existence of these minutes to the Director of Public Prosecutions (Public Prosecution Service).

6.73 Agencies must ensure that they have arrangements to keep the records secure and that only those with a "need to know" have access to them.

6.74 One copy of the minutes will be sent to parents and, where appropriate, the child, unless there are particular circumstances where to do so would be detrimental to a member of the family.

6.75 The responsibility of the parents regarding the confidentiality of the minutes should be emphasised by the Chairperson.

6.76 The family friend or supporter will not receive a copy of the minutes.

Appeals and Complaints about a Child Protection Conference

6.77 Parents and, on occasions, a child, may have concerns about which they may wish to make complaint or appeal in respect of one of the following aspects of a child protection Case Conference:

- the process of the conference
- the outcome in terms of the fact of and/or the category of initial or continuing registration
- a decision not to register or to de-register.

6.78 They should discuss their concerns with the Chairperson of the Case Conference. If they are not satisfied by this discussion they should be advised of the appeals procedure (see Appendix 4).

6.79 Complaints about individual agencies should be made to the relevant agency and responded to in accordance with that agency's complaints procedure.

6.80 If another Case Conference participant has a complaint about the process of the Case Conference he should discuss this with the Chairperson.

6.81 Where a member of the Case Conference has a concern about an individual agency's representative he should, in the first instance, speak to the person concerned. If the outcome of this is not satisfactory he should discuss this with his line manager who should refer to the appropriate manager in the relevant agency

AFTER THE CASE CONFERENCE

Role of Case Co-ordinator

6.82 The case co-ordinator must be a qualified social worker, with experience in child protection work, employed by the Trust or the NSPCC.

6.83 The case co-ordinator is responsible for:

- fulfilling the statutory responsibilities of his agency
- convening the first core group meeting within **10 working days** of the Initial Case Conference
- co-ordinating and completing the comprehensive assessment of the child and family
- developing the Child Protection Plan outlined at the initial Case Conference into a comprehensive inter-agency plan;
- acting as lead worker for the inter-agency work
- ensuring that minutes of the core group meeting are produced and distributed within **14 working days**.

The Core Group

6.84 The core group carries out the inter-agency work and includes the case co-ordinator and professional workers who have direct contact with the child and family. Parents and the child have an important role in contributing to the Child Protection Plan and should be invited to the core group meetings. The first meeting should take place within **10 working days** of the initial Case Conference in order to formulate the full Child Protection Plan and then as frequently as necessary to ensure the implementation of the Child Protection Plan.

6.85 The members of the core group will:

- co-operate with the case co-ordinator in the comprehensive assessment and subsequent Child Protection Plan
- plan and implement inter-agency work within the structure of the conference recommendations
- meet regularly to evaluate progress against the objectives of

the Child Protection Plan; and a written record of the core group meetings should be retained in the child's case file.

Comprehensive Assessment

6.86 A multi-disciplinary comprehensive assessment must be undertaken whenever a child's name is placed on the Child Protection Register. The comprehensive assessment should be completed before the first review Case Conference to enable the inter-agency child protection plan to be agreed.

6.87 The comprehensive assessment fulfils the following functions:

- provides an understanding of the child's needs and family's situation
- establishes what has happened and the reason for the concerns
- assesses the risk of the child suffering significant harm
- identifies what needs to change in order for the risk to the child to be reduced.

6.88 The comprehensive assessment will provide information for the Child Protection Plan. It should include contributions from all relevant agencies to cover social, environmental, health, developmental and educational needs. It must be remembered that assessment is a continuing activity throughout the child protection process and adjusted according to the timescale for Case Conference reviews and/or of appearances at court.

6.89 As with all aspects of the Child Protection Process, involvement of parents and the child is an essential element of an effective comprehensive assessment. The process of engaging them may take time and may delay the timetable for undertaking the assessment but their co-operation is essential.

The Child Protection Plan

6.90 All children whose names are on the Child Protection Register must have an inter-agency Child Protection Plan and must be seen by the case co-ordinator at no more than at **4 weekly** intervals and more regularly as determined by the Child Protection Plan.

6.91 The multi-disciplinary assessment will lead to a written plan of intervention agreed between participating agencies and shared with parents and, if appropriate, the child. The aim of the plan is to:

- safeguard the child from further harm
- promote his health and development
- help his parents achieve these objectives.

6.92 The Child Protection plan should:

- describe the needs of the child, giving particular attention to his safety and well being
- identify the intended outcome for the child
- identify the contribution to be made by parents and the help they need in order to safeguard the child
- identify the means by which this help will be provided
- identify the part to be played by each professional in providing this help and in monitoring the child's safety
- identify possible risks associated with the planned action and how these will be managed
- establish the pattern of contact with the family and visits to the child. The child should be spoken to by themselves where they are of sufficient age and understanding.
- set dates on which progress will be reviewed.

6.93 Other areas that should be identified in the plan are dependent upon the individual needs of the child. These may include:

- where the child should live if not at home
- recommendations with regard to contact between the child and parents if not living at home
- the child's contact with the alleged abusers, where these are family members
- what needs to change in order for the child to be considered safe within the family and how these changes will be facilitated.

6.94 If the abuser is in prison or living away from home the plan should state what will happen if he wishes to return home.

6.95 Once the plan has been drawn up it will be the responsibility of individual agencies to implement the parts of the plan relating to them and to communicate with the case co-ordinator and others as necessary. The Case Co-ordinator is responsible for co-ordinating the contributions of different agencies. The plan should not be changed without prior consultation with the core group members and the Chairperson of the Case Conference. Any changes should be confirmed in writing.

6.96 The parents and child (dependent on age) should be invited to comment on the Child Protection Plan, be afforded the opportunity to sign the plan and be given a copy of the document. The Case Co-ordinator should ensure that the family understand the plan and are prepared to work within it.

6.97 All professionals working with children and/or families in accordance with a child protection plan must be alert to indications that the plan may be failing to protect the child. These include:

- parents denying, or otherwise preventing, access to the child
- parents not co-operating in carrying out the Child Protection Plan
- any agency failing to deliver its contribution to implementing the plan
- medical monitoring being frustrated and its purposes not being achieved
- medical monitoring raising a concern that the child may be neglected or ill treated
- any other information, professional observation or reported incident, which indicates that the level of risk of significant harm has become or remains unacceptable.

6.98 In any of the above situations the professional concerned should promptly inform the Case Co-ordinator who should then give careful consideration to requesting an urgent child protection Case Conference for the purpose of sharing the new information and ensuring the continued protection of the child. Where there is concern about imminent harm, consideration should be given to

seeking to remove the child from harm; this may require the child to be placed with other safe family or friends, or if this is not deemed suitable at the time, to accommodate the child in the care of the Trust. Every effort should be made to do this with the written agreement of the child's parent, otherwise consideration must be given to the necessity for a legal order, such as an Emergency Protection Order or Interim Care Order.

Child Protection Review Case Conference

6.99 The first Review Child Protection Case Conference should be convened within **three months** of the initial Case Conference and thereafter at not more than six-monthly intervals to ensure that the Child Protection Plan continues to provide protection for the child.

6.100 The inter-agency Child Protection Plan requires regular review to ensure that it continues to provide protection for the child, that his needs are being met and continuing safety can be achieved.

6.101 Any professional may request a review Case Conference where he has cause for concern about a registered child.

6.102 The review Case Conferences will be conducted in the same way as at the initial child protection Case Conference as detailed earlier(Section 6.3 – 6.98). These are:

- membership of the Case Conference
- involvement of the parents and/or child
- exclusion of parent
- attendance of friend or supporter
- conference format
- responsibilities of the Chairperson
- reports for the Case Conference
- conference minutes
- appeals against Case Conference decisions.

Purpose

6.103 The purpose of the Child Protection Review Case Conference is to:

- ensure that the child continues to be adequately safeguarded
- identify any significant or relevant changes in the child's family since the previous Case Conference
- review the safety, health and development of the child against the outcomes of the Child Protection Plan
- examine the current level of risk to the child with reference to any assessments undertaken by agencies individually or collectively
- decide as to whether continued registration is necessary/
- consider whether a Child Protection Plan is still required, or should be changed.

Timing of the Review Child Protection Case Conference

6.104 The Chairperson of the Case Conference has discretion to delay a review Case Conference in cases where the decision about the need for a Child Protection Plan and further risk to the child may be affected by the outcome of imminent court proceedings.

6.105 Review Case Conferences should not be cancelled except in exceptional circumstances. The case co-ordinator must inform the Chair of the Case Conference if exceptional circumstances arise and cancellation needs to be considered. It is the Chairperson's decision whether the conference is cancelled or delayed and the reasons recorded in the child's case file and the minutes of any reconvened Case Conference.

6.106 All agencies have a responsibility to ensure that representatives attend review Case Conferences in order to avoid the need for postponement because a quorum is not available.

Criteria for Convening an Unscheduled Review Case Conference

6.107 Consideration should be given to convening an unscheduled review Case Conference in the following circumstances if:

- there is a significant deterioration in a child's or family's circumstances
- there is a departure from the Child Protection Plan by any agency
- it is not possible to provide the level of support and/or monitoring required by the Child Protection Plan
- a child has been reported missing to a Statutory agency
- there is a breakdown in partnership and co-operation by parents
- a known abuser joins, or is in regular contact with the family
- consideration is being given to a 'Looked After Child' returning home
- the child's and family's circumstances have improved significantly and de-registration should be considered.

Reports for a Review Case Conference

6.108 Members of the core group must provide written reports for the Review Child Protection Case Conference. These should address the progress made in the implementation of the Child Protection Plan, ongoing concern for the child, the degree of continuing risk to the child and recommendations for future work.

Children Looked After by the Trust

6.109 Separate "Looked After Child" review and child protection reviews must be held for children looked after whose names are also on the Child Protection Register. This is required in order to meet the statutory requirements under the The Review of Children's Case Regulations (NI) 1996, and also to ensure that the different issues relevant to each process are fully considered.

6.110 They may be held consecutively, however, they must be minuted separately.

Change in Registration Category

6.111 A review Case Conference may consider that a change or addition, to the registration category is necessary to reflect changing assessment and concerns.

De-registration

6.112 At every review Case Conference the criteria for de-registration should be considered. These are:

- the comprehensive assessment has shown that a Child Protection Plan is not necessary
- the child remains at home but the risk of significant harm has been reduced significantly
- the child has been placed away from home and is no longer considered to be at risk
- the child no longer has contact with the abusing person
- the child has reached 18 years of age
- the child has married
- the child has died
- the child has moved to another area and that HSS Trust, or local authority, has accepted responsibility for the child
- the child has moved permanently from the UK.

6.113 A child's name should not be removed from the Child Protection Register by a review Case Conference unless a quorum is present and a majority of members of the conference agree with this decision. The child and parents should be notified in writing of the decision and provided with a copy of the minutes, where applicable.

6.114 All those informed of the decision to place the child's name on the Child Protection Register should be notified of the removal of his name from the Register. They should be asked to amend their records accordingly and to destroy all Child Protection Case Conference records in accordance with guidance in Chapter 11 and data protection principles.

6.115 De-registration should not lead to the automatic withdrawal of support services. The child may still be assessed as a child in need under Article 17 of the Children Order. Any future support required by the child and family should be discussed at the review Child Protection Case Conference and recorded in the minutes. All agencies and professionals should accept their continuing responsibility for supporting a child and his family once the Child

Protection Procedures cease to apply. The continuing provision of services may still require inter-agency collaboration.

Case Closure

6.116 Moving out of the child protection process does not indicate case closure. A case must not be closed without discussion with the referrer, where appropriate, and any other agency that is offering support to a child.

6.117 The decision to close the case must be made by a Social Work Manager (APSW equivalent or above).

Chapter 7

The Child Protection Register

CHAPTER 7 THE CHILD PROTECTION REGISTER

7.1 Each community Health and Social Services Trust is required to keep a register of every child in its area who is considered to be suffering from, or likely to suffer, significant harm and for whom there is a child protection plan. The Register is not a list of names of children who have been abused but of children for whom there are unresolved child protection issues and who are currently the subject of an inter-agency child protection plan.

7.2 The information on the Register should be kept up-to-date and its contents should be confidential other than to authorised legitimate enquirers. It should be held securely and separately from other agency records. It should be accessible to enquirers both in and outside office hours.

7.3 The Register should be managed by the HSS Trust Director of Social Work who has responsibility for family and child care services, or his senior delegated nominee (the Register Custodian).

Purpose of the Register

7.4 Placing a child's name on the Register does not in itself protect the child from abuse. The purpose of the Register is to:

- provide a record about a child for whom there are unresolved child protection issues and there is in place an inter-agency child protection plan
- ensure the Child Protection Plan is formally reviewed at least every **six months** (and initially after **three months** of the decision to place the child's name on the register)
- provide a central point of enquiry for professional staff who are concerned about the welfare of a child and who need to know whether the child is the subject of an inter-agency Child Protection Plan
- collate enquiries to the Register in order to identify incidents of concern which, if pooled, may produce a clearer indication of risk
- gather statistics about children and the categories of abuse which can be used to determine current trends, training and resource needs.

Registration

7.5 The entry of a child's name on the Child Protection Register should only occur as a result of a decision made at a child protection Case Conference where it has been agreed that there is a risk of significant harm, leading to the need for a child protection plan.

7.6 The exception is when a child whose name is on the Child Protection Register of another HSS Trust moves into the area either temporarily or permanently. The child should be registered provisionally pending the first child protection Case Conference in the receiving HSS Trust's area. This must be held within **15 working days**. It is acknowledged that a child's name may be on two Child Protection Registers for a maximum period of **15 working days**.

Categories of Abuse for Registration

7.7 The criteria for registration is that the child is suffering or is likely to suffer from significant harm and requires a Child Protection Plan to safeguard him from harm. The categories of abuse under which a child's name may be placed on the Child Protection Register are:

Potential physical abuse
Suspected physical abuse
Confirmed physical abuse
Potential sexual abuse
Suspected sexual abuse
Confirmed sexual abuse
Potential emotional abuse
Suspected emotional abuse
Confirmed emotional abuse
Potential neglect
Suspected neglect
Confirmed neglect

A child's name may be placed on the Child Protection Register under more than one category of abuse.

Access to the Register

7.8 Access to the Child Protection Register is restricted to professionals who have a 'need to know' in order to protect the child. A 'ring back' procedure operates so that the authenticity of the callers can be verified. Those professionals who have access to the Child Protection Register are:

- ELB/CCMS Designated Officer
- General Medical Practitioner
- Senior Nurse in the Department
- NSPCC Area Children's Services Manager or above
- Police Inspector and above
- Senior Manager, Allied Health Professional
- Special Registrar (Hospital) and above
- Senior Probation Officer and above
- Designated Child Protection Officers within the Youth Justice Agency
- Senior Social Worker and above
- Senior Education Welfare Officer
- Board Designated Doctor and Nurse
- Out-of-Hours Social Work co-ordinator/team
- Trust named Paediatrician and
- Trust named Nurse.

These agencies should inform the Register Custodian in each HSS Trust of the name(s) of their authorised person(s).

7.9 The Register Custodian must:

- keep a record of the names of children about whom an enquiry is made
- ensure, if the child's name is on the Register, the name and telephone number of the case co-ordinator is given to the enquirer

- ensure if the child's name is not on the Register but there is another child on the register at the same address the enquirer will be informed of this and given the name of the case co-ordinator for that child
- ensure he will inform the relevant case co-ordinator of the enquiry made to the Register.

7.10 It is important that all enquiries about children whose names may be on the Register are through the Register Custodian so that enquiries about it can be collated. **Other information systems must not be used to check this information.**

7.11 Where an enquiry is made out of office hours the Trust's duty social worker will:

- check the Child Protection Register and follow the procedure outlined in Chapter 3 (section 3.33 – 3.34)
- advise the Register Custodian of the enquiry the next working day.

7.12 If the child's name is not on the Register and more than one enquiry has been made, the appropriate Social Worker Manager (APSW equilivent or above) will be informed by the Register Custodian. The Social Worker Manager (APSW equilivent or above) should consider the need for a child protection investigation and the decisions recorded on the child's file.

7.13 DHSSPS holds the list of custodians of Child Protection Registers for Northern Ireland. Whenever a change of Register Custodian is made this should be notified to Child Care Unit, Department of Health, Social Services and Public Safety, Castle Buildings, Upper Newtownards Road, Belfast, BT4 3SQ so that the list can be kept up-to-date.

Changes in Information or Additional Information for the Register

7.14 All professionals who are aware of changes in the information about a child whose name is on the Child Protection Register must notify the case co-ordinator. The case co-ordinator must notify the changes to the Register Custodian.

7.15 Changes that must be notified immediately are:

- child's change of address
- child's change of legal status
- any new name by which the child is known
- change of carer
- birth of child to be registered
- change of case co-ordinator
- change of school/or pre-school provision.

All changes should be confirmed in writing

Failure to see a Child

7.16 There will be occasions when a professional is prevented from seeing and talking to a child whose name is on the Child Protection Register in circumstances when they would reasonably expect to do so. This may occur in a variety of ways including deliberate refusal of entry, excuses regarding the child's alleged unavailability (asleep, out playing etc) or the family's real or apparent absence from home. In any circumstances that cause concern the case co-ordinator, or if he is not available, the duty social worker or team leader should be informed immediately. The worker receiving such information should also notify his line manager.

7.17 Strenuous attempts must be made to see the child. These should include:

- visits to the home at various times
- a letter of appointment to the house requesting to see the child
- contact with school, the Health Visitor or GP to see if they have seen the child in the last **5 working days**.

7.18 The case co-ordinator/duty social worker should discuss the case immediately with his line manager or other appropriate line manager. A decision should be made regarding an urgent visit by the case co-ordinator/duty social worker and possible further action if this visit results in failure to see the child.

7.19 In the event of an appropriate line manager not being immediately available the responsibility to visit and take further action rests with the case co-ordinator/duty social worker.

7.20 Should the case co-ordinator/duty social worker not be able to gain access to the child and family he must decide whether or not to enlist the assistance of the Police. In an emergency any worker can request police assistance to gain entry to see a child.

Children and Families Who Move

7.21 When a child whose name is on the Child Protection Register moves from or to another HSS Trust it is essential that immediate action is taken to ensure the safety of the child in the new location.

Children on the Child Protection Register Who Have Moved Out of the Trust

7.22 When any agency or professional working with a child whose name is on the Child Protection Register becomes aware of or suspects that the child and family has moved to another Trust, they must immediately inform the case co-ordinator.

7.23 The case co-ordinator must immediately inform his line manager and appropriate Social Worker Manager (APSW equilivent or above). The Social Worker Manager (APSW equilivent or above) will inform the HSS Trust Director of Social Work (or senior designated nominee) of the child's move.

7.24 The HSS Trust Director of Social Work (or designated nominee) must inform the HSS Trust Director of Social Work in the area to which the child has moved that the child's name is on the Child Protection Register and ask that the child's name is placed on the receiving HSS Trust's Child Protection Register pending a Child Protection Case Conference.

7.25 The HSS Trust Director of Social Work must ensure that a written summary of the family history and the reason for registration is forwarded within **5 working days** to the receiving HSS Trust Director of Social Work.

7.26 The case co-ordinator will also immediately notify relevant professionals in the receiving Trust of the child's move including:

- the HSS Trust Community Paediatrician/named Doctor for Child Protection
- the Trust Named Nurse for Child Protection
- Hospital Personnel, if relevant
- the Designated Teacher at the child's school, if relevant
- all other agencies/professionals who are involved with the child.

7.27 The original Social Worker Manager (APSW equilivent or above) and case co-ordinator will attend the Case Conference in the receiving HSS Trust. The Social Worker Manager (APSW equilivent or above) will ensure that all relevant information, reports and Case Conference minutes are given to the receiving HSS Trust. Consideration should be given to forwarding a copy of the child's/family case file.

7.28 The original HSS Trust will retain responsibility for the child until the Case Conference and the receiving HSS Trust has accepted responsibility for the child.

7.29 The child's name will be removed from the original HSS Trust's Child Protection Register only when the receiving HSS Trust has accepted responsibility for the child.

7.30 A record of the transfer of responsibility should be made, and signed by the original Director of Social Work, and placed on the child's file.

Children on the Child Protection Register Who Have Moved into the Trust

7.31 When any agency or professional becomes aware that a child whose name is on another Trust's Child Protection Register has moved into the area they must immediately inform the relevant Social Worker Manager (APSW equilivent or above).

7.32 The Social Worker Manager (APSW equilivent or above) must notify their Trust Director of Social Work of the child's move into the Trust.

7.33 The HSS Trust Director of Social Work (or senior designated nominee) will advise his counterpart in the child's previous Trust of the child's move and request a written summary of the family

history and the reasons for registration.

7.34 The Social Worker Manager (APSW equilivent or above) will immediately notify:

- the HSS Trust Community Paediatrician
- the HSS Trust Senior Nurse Advisor, Child Protection
- the Designated Teacher at the child's school, if relevant, of the child's move to the Trust's area.

7.35 The receiving Social Worker Manager (APSW equilivent or above) should contact their counterparts in the child's previous HSS Trust.

7.36 The HSS Trust Director of Social Work will advise the Register Custodian of the child's move to the receiving HSS Trust.

7.37 The Register Custodian will:

- place the child's name on the Child Protection Register pending a Case Conference
- advise the Register Custodian of the child's previous HSS Trust that this has been done
- ensure a Case Conference is convened within **15 working days**.

Temporary or Short Term Move

7.38 If the move is temporary or short-term the procedures below will be followed.

The Directors of Social Work from the two HSS Trusts should reach agreement about:

- on which Child Protection Register the child's name will be placed
- who will have responsibility for the child
- who will provide services to the child
- who will be the case co-ordinator.

7.39 These agreements will be confirmed in writing by the original Trust involved with the child and placed in the child's case file.

Children Who Move Jurisdiction

7.40 When a registered child moves to another jurisdiction, including the Republic of Ireland, similar action must be taken to notify the appropriate authority as outlined in Section 7.21 – 7.30.

Children on the Register Who Are Missing

7.41 At what point a family is considered 'missing' rather than 'temporarily out of touch' will depend on the known facts about the family and the seriousness of the situation. The major reason for trying to locate such families is that the disappearance may indicate that further abuse has occurred. The timescale for action will be dependent upon the assessed risk to the child.

7.42 When it comes to the attention of any professional that a child whose name is on the Child Protection Register cannot be contacted/may be missing, the case co-ordinator should be immediately informed.

7.43 Action to determine whether or not the child/family is missing must be taken if any of the following situations arise:

- concern that the child/family does not keep pre-arranged appointments
- the child/family are not engaging in their normal daily patterns (e.g. child missing from school, family do not keep appointments with other professionals)
- the family home is locked and appears uninhabited
- contacts with relatives or friends offer no explanation for the disappearance
- neighbours, relatives or friends raise concerns that the family may have moved.

7.44 If a case co-ordinator has reason to suspect the family has gone missing, this should be reported immediately to his line manager who should then discuss this with the Social Worker Manager (APSW equilivent or above).

7.45 Members of the core group must make strenuous attempts to locate the family. These include:

- repeated visits to the home at various times
- a letter of further appointment delivered to the home
- contact with other professionals e.g. school, GP, Health Visitor, Police, to ascertain their knowledge of the situation
- contact with friends or relatives to try to ascertain the whereabouts of the family.

7.46 The case co-ordinator must ensure that all relevant professionals involved in the case are notified and kept informed of the child's circumstances. The Trust Register Custodian and the custodian of the registers that are held centrally, if relevant, must be informed immediately.

7.47 When all attempts to locate the family have been exhausted, or sooner, if there are serious concerns about the child, a decision must be made by the Social Worker Manager (APSW equilivent or above) in respect of the need to convene a Child Protection Case Conference. The task will be to share all information and to consider whether to circulate details of the missing family to all custodians of the Child Protection Register on a national basis, including the Republic of Ireland.

7.48 If all efforts to trace the family fail, a senior member of the Trust's Social Services Department (Programme Manager or above) may ask assistance from the local Social Security Agency and ask for their records to be checked and, if necessary, those of the Child Benefit Office.

7.49 The Trust Custodian of the Child Protection Register is responsible for circulating details of the missing child/family to all other Register Custodians in Northern Ireland, Great Britain and the Republic of Ireland.

7.50 If the family is thought to be in Great Britain the custodian should send details of the missing child/family to Child Care Unit, Department of Health, Social Services and Public Safety, Dundonald House, Upper Newtownards Road, Belfast, BT4 3SF who will circulate the information to all custodians in Great Britain.

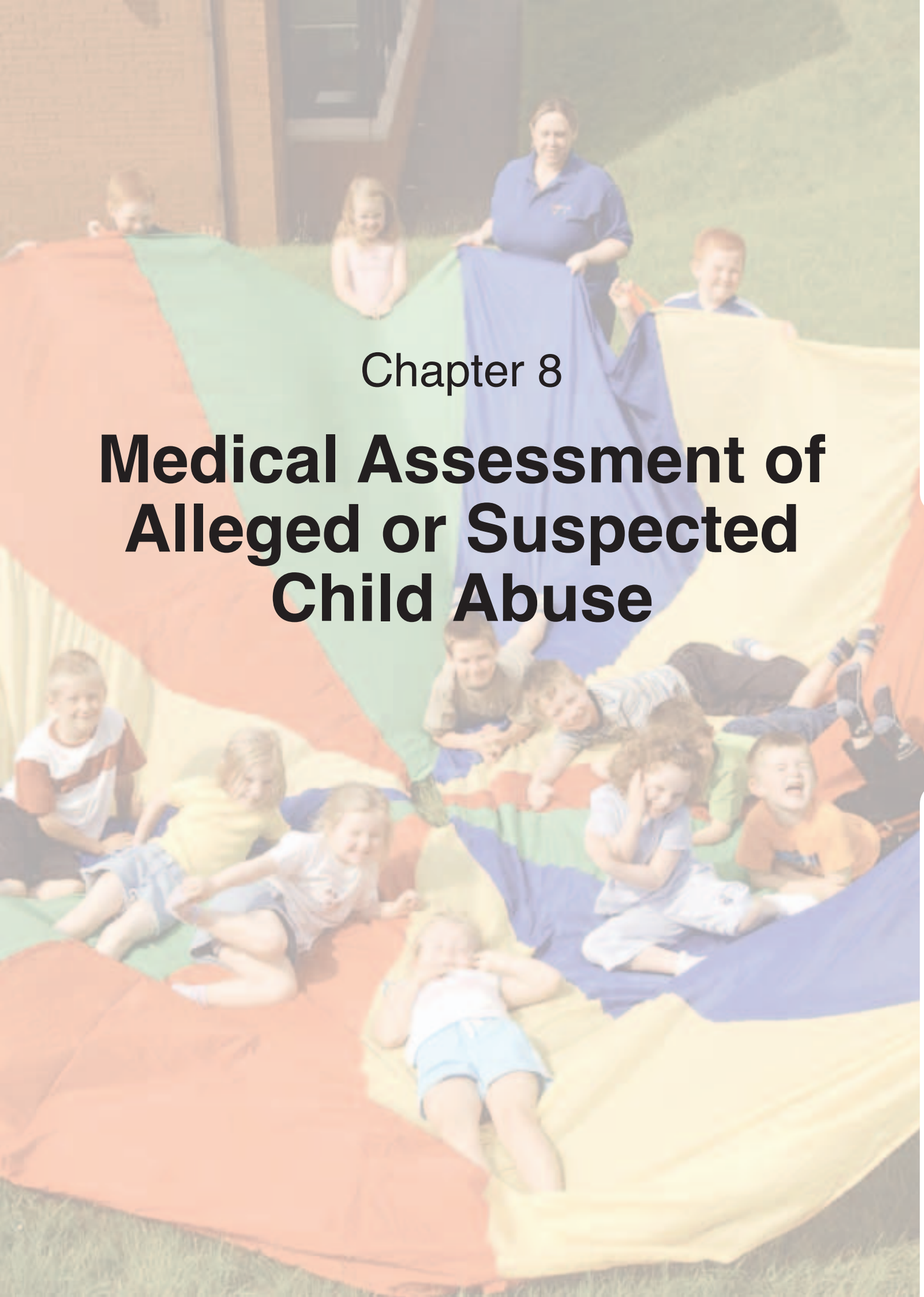
7.51 If the family is thought to be in the Republic of Ireland the Trust Custodian of the Register will send a short summary of the family and reasons for concern to all Chief Executive Officers of the eight Health Service Executives in the Republic of Ireland (see Appendix 3 for addresses).

7.52 When the family is found, all those notified that the child was missing must be informed. If the child is living in another Trust, or jurisdiction, the procedures for children and families who move must be followed.

Allocation, Service Provision and Case Closure

7.53 Trust should have systems in place to ensure that:

- the impact of staff absences on cases where there are child protection concerns are properly controlled
- cases are allocated to suitably skilled and experienced professionals who have sufficient time to undertake planned work with the child and family
- decisions about case allocation, service provision, and case closure are monitored and reported on by managers
- managers are alerted to any weakness in internal transfer arrangements across SW teams/ programmes of care across the Trust.
- Child Protection files are seen and signed by Senior Social Workers and the Social Work Manager (APSW equilivent or above) is responsible for reviewing a representative sample of cases in preparation for supervision sessions, and to sign and date the file to indicate that such a review has taken place.



Chapter 8

Medical Assessment of Alleged or Suspected Child Abuse

CHAPTER 8 MEDICAL ASSESSMENT OF ALLEGED OR SUSPECTED CHILD ABUSE

Purpose of Assessment

8.1 Medical advice should always be sought as part of the investigative process of alleged or suspected child abuse.

8.2 The general purpose of a medical assessment is threefold:

- to assist with the inter-agency assessment as to whether abuse has occurred
- to ensure that any evidence which is collected and presented is of a high quality thus ensuring that the child has the optimum level of protection and support
- to ensure that the wider healthcare needs of the child are fully identified and arrangements made to meet these needs.

The welfare of the child must remain paramount when a medical assessment is undertaken.

8.3 Medical assessments in cases of alleged or suspected child abuse, will achieve their purpose if undertaken collaboratively, ensuring that children are not subjected unnecessarily to repeated medical assessments for evidential purposes. The specific purposes of a medical assessment are to:-

- ensure appropriate diagnosis, and treatment, if necessary
- provide advice, support and reassurance (where possible) to the child and carers in a manner that will assist the process of recovery
- exclude the possibility that there are other injuries which were not immediately apparent
- assess for any other conditions, as clinically indicated, which may be suggestive of other types of abuse
- provide a medical opinion on the nature of the abuse, its likely cause and compatibility or otherwise with any history given
- obtain any forensic evidence available, if indicated

Who Should Undertake the Assessment?

8.4 Children who may have suffered abuse can be presented to doctors in a variety of ways e.g. by the Police, Social Services, hospital/community paediatrician, hospital outpatient department (including Accident & Emergency), GUM and Community clinics, e.g. Family Planning Clinics, Out-of-Hours GP Centres, Primary Care staff or AHP`s. The nature of the abuse may vary from minor to life-threatening concerns or injuries. Consequently, the question of who should carry out the examination should be determined by the situation, the clinical circumstances and the age of the child but may include a GP, senior paediatrician and/or an FMO.

In cases where joint protocol procedures have been initiated (ie. Police and Social Services investigation) and medical assessment is required the aim should be to carry out a joint medical assessment (the FMO and senior paediatrician). There may be exceptions to this arrangement but these should be decided by a strategy discussion.

8.5 In cases of alleged or suspected sexual abuse, if a medical assessment is required this should be undertaken by a senior paediatrician and/or an FMO who between them, or individually, have the necessary core and case-dependent skills required as defined in ”Guidance on Paediatric Forensic Examinations in relation to possible Child Sexual Abuse” (RCPCH and APS April 2002).

8.6 Any medical practitioner carrying out an assessment should be aware of the skills needed, the possible consequences of the examination and the need for accurate, detailed and contemporaneous notes.

8.7 The examining doctor(s) should attend any Case Conference or strategy meetings about the child, to which they are invited. If unable to attend, a written report should be sent to the Chairperson, ideally at least **2 working days** prior to the meeting.

8.8 If two medical professionals are involved in a joint assessment they should agree in advance of the assessment who will undertake which component of that examination.

8.9 Medical practitioners who have examined a child for suspected abuse and disagree in their findings and/or conclusions should discuss their reports and resolve their differences where possible; in the absence of agreement they should identify the areas of dispute, recognising their purpose is to act in the best interests of the child. Accurate documentation should be made of any discussions which take place regarding these matters.

Location & General Considerations

8.10 The venue for the examination should, ideally, be determined at a strategy discussion, where one has taken place.

8.11 The examination should be carried out in a child-friendly environment. Facilities or equipment ege.g. colposcope, camera and video recorder which may be needed should be available or readily accessible. The child should be accompanied by an appropriate supporting adult during the examination. A chaperone should be available for the examination.

8.12 If a child has any form of communication difficulty, or if English is not his first language, special consideration should be given to the need for assisted communication or the use of an interpreter.

8.13 Rarely, it may be necessary for the examination to be carried out under general anaesthetic.

Consent

8.14 The doctor(s) must obtain consent for examination in accordance with the Fraser Principles. DHSSPS guidance is available on the internet at www.dhsspsni.gov.uk. Doctors can also seek information on consent from their Trust/employing organisation or Professional body.

Professionals need to be aware of who can give consent for examination.

8.15 **Medical Assessment of Alleged or Suspected Physical Abuse**

History, Examination and Investigation

- Record person(s) present at the assessment and his (their) relationship to the child. Record those with parental

responsibility and from whom consent was obtained. Record date, time and venue.

- Record a full paediatric history, including explanations of the abuse from the child (where possible), carer, and/or other relevant person(s) present. Document when abuse was reported to have occurred. Record both times and details.
- The examining doctor(s) should consider the appropriateness or otherwise of taking certain details of the history from an adult in the presence of the child. Alternative arrangements should be available to accommodate the child separately if required.
- The examining doctor(s) should consider whether taking a history directly from the child is in that child`s best interest. The child should be offered privacy to give this history if required.
- On occasions, dispensing with consent for taking a history directly from the child may be considered by the doctor to be in that child`s best interest. In such cases the examining doctor(s) should clearly record the reasons for dispensing with consent.
- The general history should include (where possible) antenatal, neonatal, developmental, social, family and educational history (including current school or pre-school placement).
- Record parent's/carer's expressed concerns about the child e.g. behaviour, health and development.
- Document the previous medical history with specific enquiry about previous admissions/injuries. Previous hospital/community medical records should be reviewed. Consideration should be given to accessing previous information from A+E Departments, if possible.
- Consider in detail the whole child; the full examination should include measurement of growth parameters with the use of relevant, properly completed centile charts (recommended charts are available from the Child Growth Foundation), assess nutritional status, general appearance and level of hygiene, signs of neglect, overt signs of sexual abuse, emotional / behavioural disturbance, development including language and social skills. The interaction of the child with parent, carer and examining doctor(s) should be commented on.

- Diagnosis of physical abuse involves the assessment of lesions visible to the unaided eye. Accurate documentation should be achieved by means of words, drawings with measurements and photographs supplemented, where appropriate, by x-rays.
- Examination and investigations may include some or all of the following:
  - ➢ a full physical examination (always required)
  - ➢ taking of appropriate blood samples
  - ➢ photographs obtained with specific written consent
  - ➢ X-rays with access to an appropriately trained radiologist for advice e.g. full skeletal survey under 2 years of age (with follow-up chest X ray **2 weeks** later). Consider isotope bone scan in the older child
  - ➢ ophthalmological assessment
  - ➢ dental assessment
  - ➢ orthopaedic assessment
  - ➢ other expert professional opinion, as required
- There is also a need to consider if a CT brain scan should be included routinely with the skeletal survey in suspected non accidental injuries for all pre-mobile children. It is recommended that a CT brain scan is considered for all small children in whom non accidental injury is suspected, if CT is judged to be not worthwhile or indicated in that individual case, it is advisable that this be documented in the notes.
- The outcome of the medical assessment should be clearly verbally communicated immediately by the examining doctor(s) to Social Services (where appropriate) and the Police (if involved). This should be followed up with a written report as soon as practicable (and where possible within **72 hours**) being sent to Social Services, and Police upon request.
- The child's general practitioner, health visitor and any other relevant health professional should be notified of the examination.
- The examining doctor(s) should make arrangements for treatment and follow-up health care of the child as necessary.

- The examining doctor(s) should attend any Case Conference or strategy meeting about the child to which they are invited. If unable to attend, a written report should be sent to the Chairperson, at least **2 working days** prior to the meeting.

8.16 **Medical Assessment of Alleged or Suspected Sexual Abuse**

- The necessity for a medical examination, its timing, and who is /are the most appropriately trained and experienced doctor(s) to carry out the examination should be discussed immediately with Social Services and/or Police i.e. at a strategy discussion.
- The paramount consideration must be the welfare of the child, however, the need to gather forensic and/or other criminal evidence must be considered. This will occasionally necessitate an immediate Out-of-Hours response and it is essential local protocols/procedures are in place to enable this to occur.
- If two doctors are involved in a joint assessment they need to determine in advance of the examination who will undertake which component of that examination.
- The medical examination of suspected sexual abuse should never be undertaken in an Out-of-Hours GP centre.
- Children should not be unnecessarily subjected to repeated medical examinations solely for evidential purposes although repeat examination may be required in some circumstances e.g. to obtain samples for investigation of sexually transmitted infections or follow-up as medically indicated.
- The outcome of the medical assessment should immediately be verbally communicated by the examining doctor(s) to Social Services (where appropriate) and the Police (if involved) using clear unambiguous language. This should be followed up with a written report as soon as practicable (and where possible within **72 hours**) being sent to Social Services, and Police upon request.
- In any communication, well-recognised anatomical terms should be used to describe ano-genital structures.
- Notification of the medical assessment should be forwarded to the child's GP, Health Visitor and any other medical consultants involved in the care of the child.

- Screening for sexually transmitted infections should take place at an appropriate stage, if clinically indicated, with suitable arrangements for a chain of evidence. Post-exposure prophylaxis for Hepatitis B and HIV should be administered if clinically indicated.
- The significance of infection needs careful interpretation.
- Arrangements should be made for the supply of emergency contraception, if indicated, and with consent obtained in accordance with the Fraser Principles.
- The examining doctor(s) should make arrangements for any further medical follow-up and management of the child where necessary.
- Appropriate arrangements should be made for the security and storage of medical notes, photographs and videos.
- The examining doctor(s) should attend any strategy meeting/ Case Conference about the child to which he is invited. If unable to attend, a written report should be sent to the Chairperson at least **2 working days** prior to the meeting.

8.17 Colposcopy and Photo-documentation

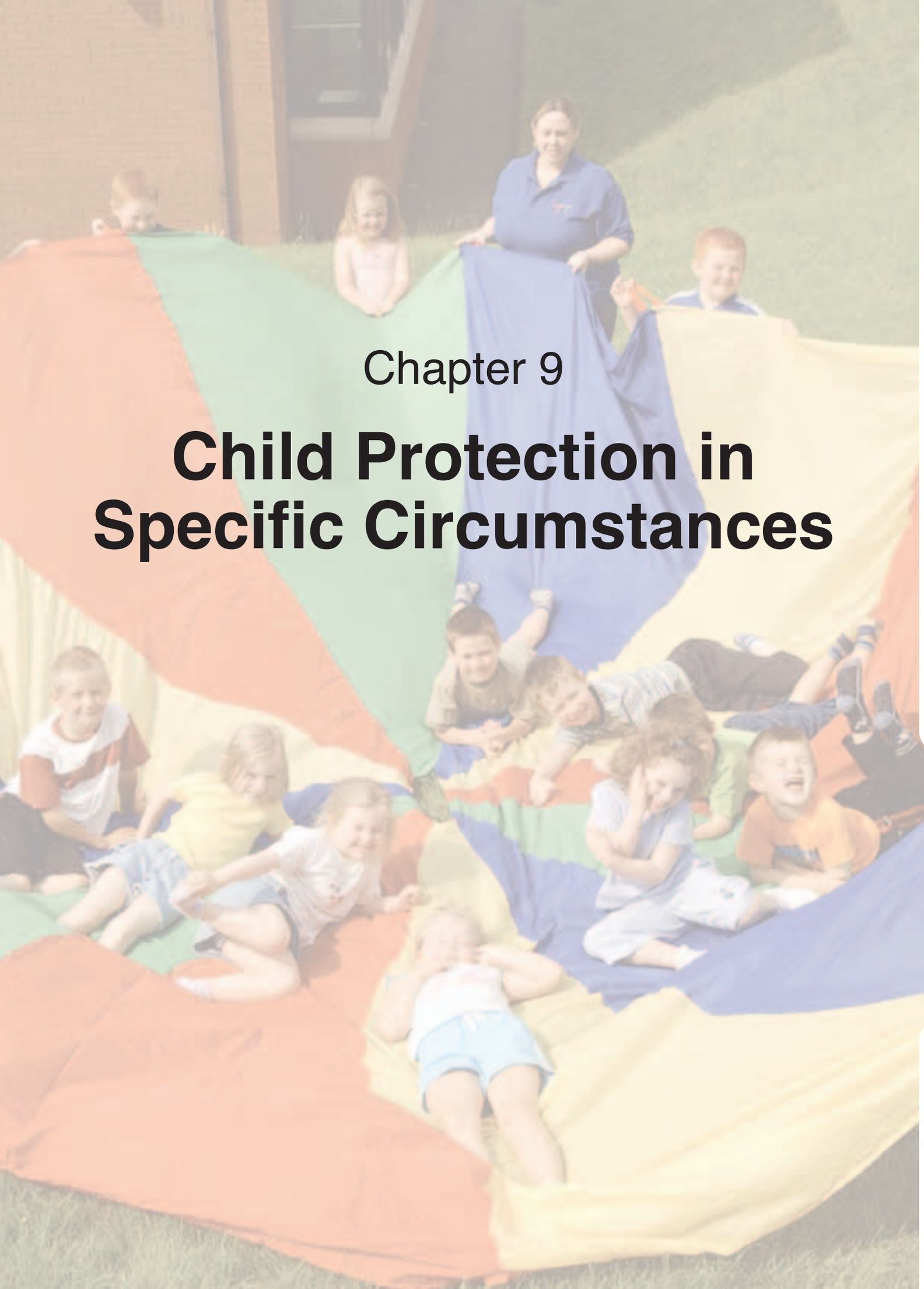
- Photo-documentation of all visible findings in abuse is recommended as a standard of good practice. The colposcope provides optimal light and magnification to assist with detailed examination of the ano-genital area and enables photography and/or a video recording of the findings. Full written consent is required (refer to section 8.14). Written consent should also be sought for the purposes of peer review, teaching or publication, if appropriate. Information must be given to the parent/carer and where appropriate the child or young person that photographs will be used to document the findings in the medical record and may be seen by other doctors who are asked to provide opinions. In legal proceedings, other medical experts may be involved who usually accept good quality photographs as evidence without the need to re- examine the child .On rare occasions, and only after comprehensive consultation with all relevant parties, re-examination may be deemed appropriate.

- Where digital photographs are used consultation with the Police in advance is strongly advised. A clear audit trail is required, including arrangements for logging all photographs taken and subsequent retention of images to maintain their integrity pending appeals, retrials and/or civil claims.

Medical Assessment of Alleged or Suspected Neglect, Failure to Thrive (growth faltering), Emotional Abuse or Fabricated or Induced Illness.

8.18 The medical assessment of suspected cases of failure to thrive (growth faltering), neglect, emotional abuse and fabricated or induced Illness is complex and should always be referred to a senior paediatrician for assessment and management. Whilst the comprehensive assessment will be inter-disciplinary and/or inter-agency, the medical component may include the following:

- a full history being taken from carers. This should include antenatal, perinatal, postnatal history and include previous medical history (including admissions), social, family and educational history. Enquiries about previous injuries, concerns or attendance at hospital or community clinics
- document person(s) with parental responsibility and any information about previous Court Orders or Social Services involvement
- review any hospital (including A+E) or community medical records and liase with other professionals e.g. Health Visitor, school nurses and AHP's
- record history, examination and investigations
- the findings of the medical assessment should be forwarded to Social Services, and Police (if applicable) as soon as possible, recognising that often these complex diagnoses are made only after a period of inter-disciplinary, inter-agency assessment and review
- the examining doctor should attend any strategy meeting/Case Conference about the child to which they are invited. If unable to attend, a written report should be sent to the Chairperson at least **2 working days** prior to the meeting.



Chapter 9

Child Protection in Specific Circumstances

CHAPTER 9 CHILD PROTECTION IN SPECIFIC CIRCUMSTANCES

Stranger Abuse

9.1 A stranger is defined as a person not previously known to the child/family. Such situations should normally be referred directly to the Police as they always require criminal investigation. The Policy & Procedures will not normally apply where a child has/is suspected to have suffered harm by a stranger except in the circumstances described below.

9.2 Child Protection Procedures should be implemented where there is concern that parents or an organization with a duty of care towards the child has failed to provide adequate supervision, which may have contributed to enabling the offence to occur, or the response to the incident may have been inadequate or inappropriate.

9.3 Where the Police consider that the child or family is in need of support and/or therapeutic input, the consent of the family and, as appropriate, the child, should be obtained and the matter referred to Social Services under Article 18 of the Children (NI) Order 1995.

Child Protection in Hospital Settings

9.4 Each hospital should have an admission and discharge policy, which states:

- that the doctor or nurse admitting a child for whom there are concerns regarding harm or neglect should obtain all relevant information from any previous admissions of the child to that or any other hospital
- that the consultant in charge of a child's case should review all information known about the child, from whatever source, when making decisions about the child's future care and management
- that decisions made and actions taken about a child's welfare are made on the basis of available information
- that hospital social work staff are involved in discussions about the needs of the child and their family
- the identity of the person(s) responsible for agreed action, a

flag which indicates that agreed actions have been completed and who actually completed them

- the need for a systematic and rigorous approach to the investigation and management of a case of possible harm/neglect on a par with other potentially fatal diseases
- permission to discharge the child should be sought from the consultant in charge of the child's case
- arrangements should be in place to safeguard the child's welfare on return to the community
- consultation with medical, nursing staff and social services staff in the community should take place
- there must be a documented discharge plan, which has the support of the consultant responsible for the child's discharge and which details: how the child's needs, including health needs, will be met in the community
- where a child does not have a GP, it is the responsibility of the consultant/ paediatrician making the decision to discharge to ensure that arrangements are made for the child to be registered with a GP.

Children Living Away From Home

9.5 Children living away from home includes those being cared for in residential settings e.g. schools, supported lodgings, holiday centres, health settings and youth justice etc and those in foster care. It is the responsibility of the agencies looking after children living away from home to safeguard them from all forms of abuse. Given the vulnerability of these children, all agencies should apply the following safeguards:

- children should be valued and respected and their self esteem promoted
- residential settings should be open to external scrutiny by families and the wider community
- organisations operating residential facilities should have child protection procedures which must be in keeping with Area Child Protection Committees Child Protection Procedures
- staff should be trained in all aspects of safeguarding children and in particular they should know how to implement child protection procedures

- there should be a designated member of staff to deal with child protection issues
- children should have access to adults outside the setting and be aware of helpline services
- there should be complaints procedures appropriate for children and all complaints should be recorded together with the outcome
- recruitment and selection procedures should be designed to prevent potential abusers from gaining employment in residential settings providing care and/or treatment for children and young people
- there should be procedures to enable staff to express concern about the conduct of colleagues. The interests of "whistle-blowers" are now protected by the Public Disclosure (NI) Order 1998
- there should be effective supervision by and support for, all staff
- staff should be aware of the vulnerability of children in their care to abuse by others e.g. colleagues, peers and others with whom the child may have contact.

9.6 Children living away from home may experience physical, sexual, or emotional abuse or neglect. Such abuse may be perpetrated by adults or peers. Staff should be alert to possible indicators of abuse e.g. changes in behaviour, self-harm and persistent absconding. Institutions should have systems in place to provide the children in their care with the opportunity to express concerns or worries. Where there are concerns that abuse has or may have occurred it is the responsibility of the agency to initiate their child protection procedures and refer the matter to Social Services and the Police, as appropriate.

9.7 Agencies/institutions must ensure that a person independent of the institution interviews any child who engages in persistent absconding to establish if abuse was a contributing factor. Such interviews should be fully recorded and placed in the child's file/record. Where abuse is considered to be a contributing factor, the Child Protection Procedures must be adhered to as referenced in Chapter 5.

Foster care

9.8 Foster care (including placements with relatives and friends approved as foster carers) is undertaken in the private domain of the carer's own home, which may make it more difficult to identify abuse.

9.9 Social Workers visiting children in foster care should be alert to the possibility of abuse. This may take the form of physical, sexual or emotional abuse or neglect and may be perpetrated by adults or peers.

9.10 Social Workers must see foster-children on their own in accordance with statutory requirements and with the 'Looked After Children Policy and Procedures':

- to encourage them to talk openly about their experiences
- to make a written record of their discussion and file in the child's case notes.

9.11 Foster carers must monitor the whereabouts of children in their care, their patterns of absence and contacts. Foster carers must notify Social Services of an unauthorised absence of a child or of any concerns they may have.

9.12 Where there are grounds to believe that a child in foster care or other child within the household is suffering/likely to suffer significant harm, the concerns should be acted upon in accordance with procedures outlined in Chapter 5 of this document. Trusts or agencies involved with the foster placement should be informed and participate as appropriate in subsequent decision-making. Where children are placed outside their own Trust area, the Trust in whose area the child is placed must also be notified immediately of any child protection concerns.

9.13 Investigations should consider the safety of any other children living in the household, including the foster carer's own children. In particular there will be a need at an early stage to consider whether the child or other children in the home should remain there pending further enquiries.

9.14 Where there are concerns that a child has been abused by a foster carer detailed guidance is provided in the section below.

Allegations of Abuse by a Professional, Carer or Volunteer

9.15 Children can be subjected to abuse by those who work with them in any setting.

9.16 Organisations which provide services for children (including day-care, leisure, churches, other places of worship and voluntary services) should have written Child Protection Procedures which include guidance for handling allegations of abuse by a professional, staff member, carer or volunteer.

9.17 All allegations of abuse of children, whether of a specific or generalised nature, by a professional, staff member, foster carer or volunteer, whether current, historical or both, must be investigated in accordance with Chapter 5.

9.18 Investigation into abuse by professionals, carers, or volunteers may well have three related, but independent strands:

- child protection inquiries, relating to the safety and welfare of any children who are or who may have been involved
- a police investigation into a possible offence
- disciplinary procedures, where it appears that the allegations may amount to misconduct or gross misconduct on the part of staff. A similar process will need to be in place for responding to concerns about volunteers. In the case of foster carers and day-care providers, issues of continuing approval will need to be addressed.

9.19 The facts of the alleged abuse must be considered within each of the three strands of possible enquiries/investigation.

9.20 The child's interests are the paramount concern and his views and wishes must be given careful consideration at all times.

9.21 When allegations of abuse by a professional, staff member, carer or volunteer are received Procedures outlined in Chapter 5 should be instigated and the following additional action taken:

- the manager for the relevant service must be informed immediately
- the senior manager/s responsible for any child in placement must be informed immediately

- where allegations relate to foster carers, the relevant manager responsible must be informed and must ensure that no further placements are made until the matter is resolved. Senior managers for all children placed must be informed of the allegation and ensure the placements are immediately reviewed, taking account of the information received.

Investigating Organised Abuse

9.22 For the purpose of these Procedures, organised abuse means abuse that may involve a number of abusers, a number of abused children and often encompasses different forms of abuse.
It involves an element of organisation. Please refer to 6.18 to 6.24 of 'Co-operating to Safeguard Children'.

Abuse of Children with Disabilities

9.23 Disabled children have the same rights to protection from harm as all other children. This requires the responsibility of parents, carers, the community and voluntary and statutory agencies to ensure the effective prevention of child abuse and neglect. Disabled children have the same needs as other children.
They may also have additional needs associated with their disability, however, which may increase their vulnerability to abuse.

Vulnerability to Abuse

9.24 Children with Disabilities

- children with disabilities are often more dependent on adults, e.g. in their intimate care needs and may be cared for by a number of different adults. Such children often spend a lot of time away from home
- children with disabilities may be unable to recognise abusive behaviour because they may have learning difficulties or a lack of awareness, of education or information, and because they may have reduced exposure to the norm of adult/children interactions. For example, a child with disabilities may have difficulty in differentiating between appropriate and inappropriate touching
- many children, particularly those with physical disabilities, have a poor and/or incomplete body image and therefore may not recognise inappropriate behaviour

- children with a communication disability may be unable to convey their experiences to others or adults may be unable to communicate with them
- children with disabilities often have low self-esteem and may not be confident about the outcome of telling of the abuse
- a disabled child's behaviour might be modified through medication.

9.25 **Societal/Procedural:**

- opportunities created for disclosure of abuse often do not meet the needs of children with disabilities e.g. telephone helplines
- behaviour indicative of abuse is often perceived to be behaviour associated with impairment rather than abuse
- "it is not the impairment itself that places these children at risk, but adult responses to that impairment". (Kennedy, 1998)
- there is still societal and possibly professional reluctance to accept that children with disabilities could be abused
- a disabled child spends time in segregated services
- the devaluation of children with disabilities in our culture creates fertile ground for abuse and also gives a clear message which creates vulnerability and powerlessness
- a disabled child is targeted by an abuser because he/she seems unlikely to be able to tell what has taken place.

Intimate Care

9.26 Intimate care may be defined as an activity required to meet the personal care needs of each individual child in partnership with the parent, carer and the child. Parents have a responsibility to advise on the intimate care needs of their child. Intimate care can include:

- washing
- dressing / undressing
- toileting
- oral care
- menstrual care

- feeding
- treatments such as enemas, suppositories, enteral feeds.

9.27 Staff involved with childrens' intimate care need to be sensitive to their individual needs. Staff also need to be aware that some adults may use intimate care as an opportunity to abuse children and have to bear in mind that some care tasks / treatments can be open to misinterpretation.

9.28 Only named staff within an agency should undertake the intimate care of children. The nature of the intimate care required should be clearly understood and recorded.

9.29 If a child appears inappropriately distressed or uncomfortable when personal care tasks are being carried out, the care tasks should stop immediately. Try to ascertain why the child is distressed, provide reassurance and report this as soon as possible to the designated manager/teacher and parent/carer. It is important to follow the relevant agency's reporting and recording procedures.

9.30 Each agency providing services that necessitate or include intimate care services should have an Intimate Care Policy and Guidelines regarding children.

9.31 All staff must be trained in the specific types of intimate care that they carry out, and also be familiar with, and fully understand the Intimate Care Policy within the context of their work.

Referral Investigation/Assessment and Treatment Process

9.32 In some Trust areas services for children with a disability are delivered through the Family and Child Care Programme. In these circumstances, the existing social worker for the child may also carry out child protection responsibilities. In other Trusts there may be a separation of the responsibilities for supporting a child who has a disability, and for investigating referrals of a child protection nature. This flow chart is designed to facilitate this latter scenario:

Investigation Process for Disabled Children

Referral of a child with a disability for investigation - From Self-referral/parent/public/professional practitioner

Referral to Child Care Team → Child Care Team to notify & follow up in writing to the Disability Team (**Purpose: information sharing**)

Child Care Team takes lead responsibility for the Child Protection Process

If single or joint investigation proceeds, the decision needs to be taken whether it is in the best interests of the child for either a child care social worker or a disability social worker to complete the investigation.

DECISION TAKEN

Child Care Social Worker
Input from the Disability Team on the particular areas of expertise can assist the investigative process e.g. communication disability social worker and

Disability Social Worker
The Child Care Team Leader will take the professional lead. There will be a need for clear communication involving the the Team Leaders for disability and child care.

At all times when the child protection issues are being investigated the Child Care Team retains responsibility. The Disability Team continues to retain all other responsibilities related to supporting the child's disability.

If the outcome continues to Case Conference or case planning, the Child Care Team and the Disability Team continue to work together on the Child Protection Plan or Case Plan, which meets the individual needs of the child.

Assessment and Treatment

9.33 Disabled children who have experienced abuse should have access to an appropriate assessment with a multi-disciplinary Child Protection Plan or Case Plan. The plan should ensure that particular consideration is given to the needs of the child's disability e.g. a realistic timeframe to complete the plan. It is important that the treatment involves the parents and carers as appropriate.

Children who Sexually Abuse Others or Display Sexually Harmful Behaviour

9.34 It is important that these procedures are applied irrespective of **who** is the victim i.e. an adult or children, or the **nature** of the offence i.e. contact/non contact.

9.35 Whether a child is responsible for sexually harmful behaviour, is a victim of sexual abuse, or both, it is important to apply principles that remain child-centred. Sexually harmful behaviour by children must be recognised as harmful to both the victim and the child who abuses. A child who engages in abuse of this kind may be suffering, or be at risk of, significant harm and may himself be in need of protection. A significant proportion of children who abuse may have been abused themselves. While the numbers who engage in this kind of sexually harmful behaviour are relatively small, particular concern remains about the reducing age of the children involved and the potential number and range of victims, which can also include adults.

9.36 Sexually harmful behaviour, when identified in children, must be taken seriously by all agencies. It is important to distinguish between behaviours which are experimental in nature and those that are exploitative and harmful. In assessing such distinctions, it is necessary to consider issues of:

- consent (including age and level of understanding)
- equality
- authority and control
- co-operation
- compliance
- criminal offences.

9.37 When abuse of a child is alleged to have been carried out by another child, a Child Protection Investigation should be carried out in accordance with Chapter 5 of these Procedures

9.38 Social Services should ensure that children for whom there are concerns about sexually harmful behaviour must be considered for assessment and treatment at specialist projects where work is done with such children.

9.39 The specific projects have staff trained:

- to provide consultation and advise
- to assess risk
- to offer treatment programmes for young people who are responsible for sexually harmful behaviour towards others.

Principles

9.40 The following principles underpin effective child protection intervention in respect of children who sexually abuse others:

- in any intervention, the welfare of the child victim must always be paramount, and this overrides all other considerations.
- the needs of children who abuse others should be considered separately from the needs of their victims. Intervention and treatment should occur as soon as possible
- the child involved in offending behaviour should be held accountable for his actions, with consideration given to his age, understanding and level of maturity. This may involve criminal prosecution
- there should be a co-ordinated approach by child welfare and youth justice agencies. This should include appropriate communication between those professionals working with the victim and those working with the child who sexually abuses others.

Individual comprehensive/multi-professional assessments should be carried out in relation to both the victim and the child who sexually abuses others.

Assessment of Risk and Need

9.41 A child who displays sexually harmful behaviour may be suffering, or be at risk of, significant harm. In such circumstances, an Initial Case Conference must be convened (refer to Chapter 6).

9.42 The Child Protection Case Conference in addition should address the following:

- the nature and extent of the harmful behaviour (expert professional judgement may be required)
- the child's level of understanding and acceptance of the abuse
- the need to complete a risk analysis in relation to the child and his family
- the need to consider the broader risk in relation to public safety
- the parent's/carer's attitude and level of understanding in relation to the abuse and their capacity and ability to protect against it
- the child's need for services and support to address his offending behaviour and who is best placed to provide these.

9.43 A full multi-disciplinary, inter-agency assessment must be carried out in respect of all children suspected of sexually abusing others, and their families, to decide the most appropriate level of intervention and assessed level of risk. A multi-disciplinary assessment should include all relevant professionals and should include the following:

- assess risk
- identify the child's needs
- take into account his age and stage of development
- his likely response to personal change programmes to tackle offending behaviour.

9.44 Where this threshold is not met, the needs of the child must be considered through the multi-agency Case Planning Process and reviewed regularly. A multi-agency plan is also required.

9.45 When the child who has been involved in sexually harmful behaviour can no longer live at home, the Trust, in consultation with

the family and other relevant agencies, should consider arrangements for care, accommodation, education and supervision pending a comprehensive assessment.

Intervention Treatment

9.46 Treatment programmes should be tailored to meet the individual needs of each child or young person. The purpose of treatment is to change those identified risk factors that are amenable to change. In order to achieve such an outcome, a multi-agency, multi-systemic approach should be actively considered and a structured programme offered. The components of treatment programmes could as a minimum include:

- an acceptance of responsibility
- victim awareness and empathy
- cognitive distortion
- sexuality and relationships
- communication, personal and social skills
- assertiveness training
- family dynamics
- identification of risk factors.

Protecting Sexually Active Children from Abuse

9.47 This procedure has been customised from one developed by Sheffield ACPC and which was commended by the Bichard Inquiry Report as providing useful guidance for agencies/professionals working with sexually active young people.

It is designed to assist those working with young people to identify where these relationships may be abusive, if the young people may be in need of protection and in particular, when a referral to the Police and child protection agencies is necessary. It should also be read in conjunction with the requirements of the Joint Protocol.

The procedure has been written on the understanding that most young people under the age of 18 will have a healthy interest in sex and sexual relationships. It is also based on the premise that those who are believed to be engaged in, or planning to be engaged in,

sexual activity should have the opportunity for their needs for health education, support and/or protection assessed by the agency involved.

In assessing the nature of any particular behaviour, it is essential to look at the facts of the actual relationship between those involved. Power imbalances are very important and can occur through differences in size, age and development and where gender, sexuality, race and levels of sexual knowledge are used to exert such power (Of these, age may be a key indicator, e.g. a 15 year old girl and a 25 year old man).

Factors to consider

In order to determine whether the relationship presents a risk to the young person, the following factors should be considered:

- whether the young person is competent to understand, and consent to, the sexual activity he is involved in
- the nature of the relationship between those involved, particularly if there are age or power imbalances as outlined above
- whether overt aggression, coercion or bribery was involved including misuse of substances as a disinhibitor
- whether the young person's own behaviour, for example through misuse of substances, places him in a position where he is unable to make an informed choice about the activity
- any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship
- whether the sexual partner is known by the agency as having other concerning relationships with similar young people
- whether the young person denies, minimises or accepts concerns
- whether methods used to secure compliance and/or secrecy by the sexual partner are consistent with behaviours considered to be 'grooming' as per sexual exploitation.

If, at this stage, there are concerns that the young person may be at risk of sexual abuse or exploitation through prostitution, a referral to Social Services/the NSPCC or Police should be made in line with Chapter 5 of these procedures.

Following any referral to Social Services there may be one of three responses:

- no further action deemed necessary or
- an initial assessment undertaken which may identify the young person as a child in need and additional services provided, or
- an initial assessment undertaken which may identify the young person as a child at risk of significant harm and in need of child protection intervention.

Wherever possible, appropriate support should be offered and agencies should continue to offer the services provided.

Young people under 14 years old

In all cases where the sexually active young person is under the age of 14, there must be a discussion with Social Services who will make the necessary enquiries and will consult with partner agencies, including the Police, as appropriate.

This discussion should be informed by the guidance in this section and, in the majority of cases, may be largely for the purposes of consultation and information sharing. In order for this discussion to be meaningful, the young person will need to be identified, as will their sexual partner if details are known.

In the vast majority of cases, it will not be in the best interests of the young person for criminal or civil proceedings to be instigated. Police and Social Services may hold vital information that will assist in any clear assessment of risk, however. Whether or not to support a victim in making a complaint to the Police should be the subject of professional judgement, taking advice as and when appropriate.

Action to be taken when a girl under 14 is found to be pregnant will be informed by these regional ACPC child protection procedures, but, again, such children should always be the subject of a discussion with Social Services/Police.

Young people between 14-17 years old

Sexually active young people in this age group will still have to have their needs assessed using this procedure. Discussion with Social Services is not mandatory and will depend on the level of risk/need assessed by those working with the young person. The same considerations as to making a criminal complaint apply as set out above in "Factors to consider".

This difference in procedure reflects the position that, whilst sexual activity under 17 remains unlawful, young people under the age of 14 are deemed unable to give consent to such sexual activity.

Young people under 18 and over 17 years old

Although sexual activity in itself is not an offence over the age of 17 (or 16 if the person is married) young people under the age of 18 may still be in need of protection. Consideration still needs to be given to issues of sexual exploitation through prostitution and abuse of power in circumstances outlined above. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. Young people over the age of 17 and under the age of 18 are not deemed able to give consent if the sexual activity is with an adult in "a position of trust" or a family member as defined by the Sexual Offences Act 2003.

Any girl who is pregnant, either under or over the age of 14, should be offered specialist support and guidance by the relevant services. These services will also be a part of the assessment of the girl's circumstances.

Bullying

9.48 Bullying may be defined as deliberately hurtful behaviour usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are physical (e.g. hitting, kicking, theft), verbal (e.g. racist or sectarian remarks, threats, name-calling) and emotional (e.g. isolating an individual from the activities and social acceptance of his peer group). The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm).

9.49 All settings in which children are provided with services or are living away from home should have in place, policy and procedures to respond to and protect children from bullying.

9.50 The framework in accordance with Chapter 5 of this Procedure should be instigated in the following circumstances:

- anti-bullying procedures have failed to be effective
- bullying is persistent and severe, resulting in the victim suffering/likely to suffer significant harm
- there are concerns that the bullying behaviour is indicative of the bully suffering/likely to suffer significant harm
- where concerns exist in relation to the parent's/carer's capacity to meet the needs of the child (either victim or bully).

9.51 The needs of the victim and the bully should be considered separately taking account the family situation and the wider environment.

Violence at Home

9.52 Domestic violence affects all members of a household. Given the vulnerability of children they are particularly susceptible to the impact of domestic violence which may affect their emotional, psychological, physical and sexual development.

9.53 In domestic violence situations professionals must ensure they maintain a clear focus on the child's welfare.

9.54 It is essential that a co-ordinated inter-agency and multi-disciplinary approach is adopted to effectively address this issue. This involves a range of responsibilities including:

- prevention through education/awareness programmes
- detection of domestic violence
- assessment of children's needs
- treatment programmes for children
- support for non-abusing parents
- programmes for domestic violence perpetrators.

9.55 All agencies must work collaboratively to tackle this problem, e.g. share information, knowledge, resources and expertise.

Legislation

9.56 The majority of children who have experienced domestic violence meet the definition of 'children in need' as outlined within the Children (NI) Order 1995. Research findings have clearly highlighted a correlation between the incidence of domestic violence and child abuse. Given this, professionals must be alert to the likelihood that child protection issues may be present.

9.57 Domestic violence has a detrimental impact on children in a number of ways:

- pre-natal assault (domestic violence may increase during pregnancy and the period immediately after pregnancy)
- witnessing the violence
- forced involvement with violence
- direct abuse – physical, emotional, neglect and sexual abuse

Children may experience a combination of these to varying degrees.

9.58 The needs of children who live in situations where domestic violence is the main source of concern are most effectively met by providing advice and support to parents.

9.59 Professional judgement must determine when to make an onward referral to another agency, whether for family support or child protection.

Actions

9.60 Where there are grounds to believe that a child is suffering or is likely to suffer significant harm, a referral must be made to Social Services, the NSPCC or the Police.

9.61 The following are examples of situations where implementation of child protection procedures should be considered:

- where there is a child present at the time of a domestic violence incident
- where a child is injured as a result of domestic violence

- where there is serious injury or hospitalisation of a victim following domestic violence
- where there is previous knowledge of domestic violence and the non-abusing parent has had to leave without the child.

9.62 Immediate contact should be made with a family if there is concern that possible harm is imminent to a child or non-abusing parent.

9.63 Discuss with the referrer how safe contact can be made with the family e.g. an interview at a venue outside the family home, telephone contact rather than written communication, etc.

9.64 Professionals need to be alert to the fact that domestic violence or the threat of domestic violence may continue after the non-abusing parent and the children have separated from the perpetrator, or through subsequent contact arrangements (including arrangements for 'Looked After Children' and in relation to contact via applications under Article 8 of the Children Order).

Substance Misuse

9.65 This section relates to the abuse of substances such as alcohol, solvents prescribed or illegal drugs. Children may need safeguarding in situations of substance abuse in the following circumstances:

- where the child is taking substances and
- where the parent/carer is abusing substances to the extent which impairs their capacity to care for the child.

9.66 Those who are providing support/services to a parent/carer who is or may be abusing substances must consider the possible impact the substance abuse has on the individual's capacity to parent the child.

9.67 A parents substance misuse problems may mean that his children do not receive the level or quality of care which all children need and which a parent wishes to provide. In such situations, the needs of the child must come first. Agencies must ensure that the child's needs, including any need for protection are thoroughly assessed so that the right services and support can be provided and families can be helped to provide good quality care.

9.68 A parent who misuses substances should be treated in the same way as other parents whose personal difficulties interfere with or lessen their ability to provide good parenting.

9.69 Agencies working with children in general, and in particular abused or neglected children, should be alerted to the possibility that one of the contributing factors to abuse or neglect may be substance misuse by a parent. All child protection assessments, whether for conference or care proceedings, should include consideration as to whether substance misuse is an element in the situation.

In situations where it is considered that substance misuse may impact on the child's welfare or that of an unborn child, a comprehensive assessment of the relationship between substance misuse and the child's welfare must be undertaken. Any assessment should include information and opinions from all agencies involved, including any specialist drugs/alcohol agency.

Pregnant Women and Substance Misuse

9.70 Most women with substance misuse problems are of child-bearing age. She may be in poor health, undernourished and may have housing and financial problems. She may be frightened at the prospect of giving up substances and anxious that her baby will be born dependent on substances.

9.71 Where there are grounds to believe that a child is suffering/likely to suffer significant harm, they should be acted upon in accordance with Procedures outlined in Chapter 5 of this document.

Commercial Sexual Exploitation of Children

9.72 Children involved in prostitution and other forms of commercial sexual exploitation should be treated as victims of abuse and have their needs assessed sensitively, pursuant to Article 18 of The Children (NI) Order 1995. They will meet the criteria for children in need, as defined in Article 17 of the Children Order and may be in need of protection.

9.73 The primary concern of anyone who comes into contact with a child who is involved in, or at risk of becoming involved in, prostitution must be to safeguard and promote the welfare of the child.

9.74 Prostitution involving children has been defined by the United Nations Commission on Human Rights as “the act of engaging or offering the services of a child to perform sexual acts for money or other consideration with that person or any other person”.

9.75 There are some key principles which relate specifically to this area of work:

- the child is treated as a victim of abuse and should have his needs assessed accordingly
- a child cannot give his informed consent to sexual exploitation
- a child’s individual circumstances, needs and vulnerabilities must be assessed including those arising from ethnic origin, disability, religion and sexual orientation
- professionals are responsible for ensuring that their actions do not reinforce the child’s involvement in sexually exploitative activities, for example, taking photographs of a child
- a child needs to be enabled to make realistic choices, and therefore needs support and effective provision for exiting from exploitation through prostitution
- where there is knowledge or strong suspicion that more than one child is involved in such activity, there will be a need for additional planning in accordance with paragraph 9.22 on organised and multiple abuse.

9.76 Children are forced and groomed into providing sexual services and they receive a return linked to these activities. The return may be:

- monetary
- other types of rewards or temporary alleviation of real or imposed problems, for example, those arising from housing needs, drug use, relationship dependency.

9.77 Either because of their age or their health needs, however, children are unable to give truly informed consent to this activity.

9.78 Children estranged from their families and communities are particularly vulnerable. They may be known to one another, be the victims of peer group pressure or even violence.

9.79 Where a child is 'Looked After' by the Trust and there is suspicion or knowledge that he is exploited through prostitution, there will need to be an assessment of the child's needs and welfare.
The 'Looked After' child's known or suspected abuse through prostitution should be addressed within the Care Plan, which should be amended as necessary unless there is evidence that the carer has failed to protect the child, in which case these Child Protection Procedures should be invoked.

9.80 The multi-agency approach is fundamental to working with this group of children. Whilst the Police and Social Services are the lead agencies as per the Joint Protocol, all agencies, statutory and voluntary, have a part to play in issues of identification, assessment, protection and service provision.

9.81 The Department of Health's Guidance, "Safeguarding Children involved in Prostitution" (published May 2000) which is aimed at Police, Health, Social Services, Education and other agencies, highlights the importance of prevention, protection and re-integration strategies.

9.82 From the earliest point of recognition and contact with a child abused through prostitution, there should be plans to reduce the harmful effects of this and work towards assisting the child to make an exit from prostitution. Exit strategies need to be based on a multi-agency assessment.

9.83 Services provided by agencies may include:

- safe accommodation
- sexual health advice
- drug advice
- mentoring to return to education or employment/training
- counselling in relation to self-esteem and psychological health
- help to pursue leisure activities
- help to develop a protective network of friends and relatives who can continue to support.

9.84 Referring knowledge or suspicion of exploitation of a child through prostitution is essential and the following procedures should apply:

- if an individual has knowledge or suspicion of a child being at risk of suffering significant harm through sexual exploitation, this should be referred to the Police or Social Services
- if there are immediate risks to a child's safety, emergency protection measures should be taken.

9.85 All referrals should be treated seriously and the key elements of the Child Protection Process outlined in Chapter 5 should be followed if there are concerns about the capacity of a parent/carer to safeguard and promote the child's welfare.

Adults Involved in Sexual Exploitation of Children

9.86 When any adult is investigated for, charged with or convicted of criminal offences concerning the sexual exploitation of children, the relevant agencies will assess what action, if any, needs to take place in respect of any child for whom the adult in question has parental responsibility and/or professional contact.

The Risks Posed by Developments in Communications Technology

9.87 The Internet has become a significant tool in the abuse of children and/or the distribution of child pornography. It provides a means by which adults can establish contact with children with a view to "grooming" them for inappropriate or abusive relationships.

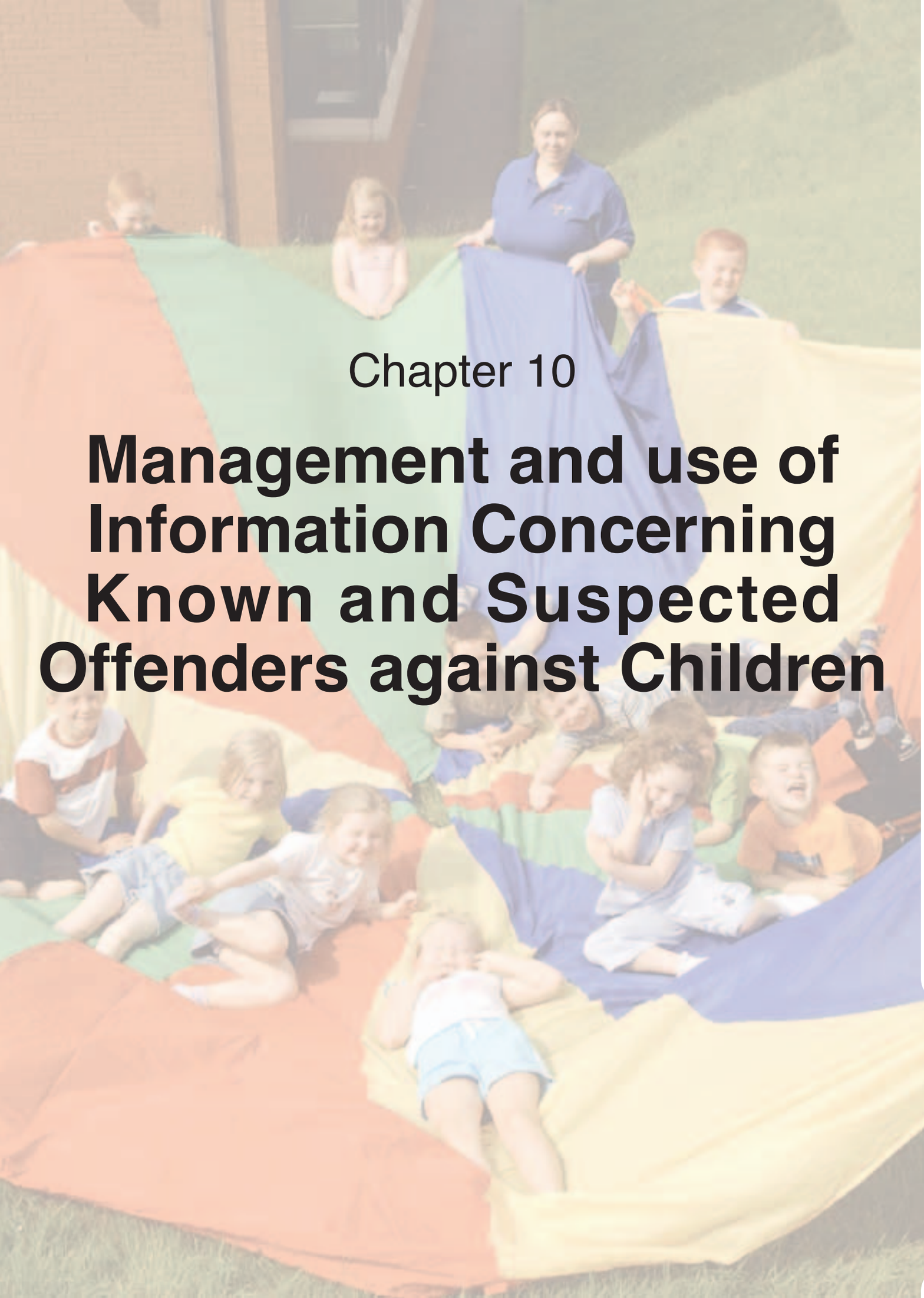
9.88 It is a criminal offence to abuse a child or to distribute or download child pornography via the Internet.

9.89 When someone is discovered to have either abused a child on the Internet, placed child pornography on the Internet or to have accessed it, the matter should be referred to the Police who will investigate. The Police will liaise with Social Services with a view to establishing whether the individual concerned has been involved in the abuse of children. It is also important to establish the individual's access to children within his family and employment contexts and in other settings, for example, work with children as a volunteer. If there are particular concerns about one or more specific children, there may be a need to carry out inquiries under Article 66 of the Children (NI) Order 1995 in respect of that child or those children and the Procedures in Chapter 5 should be followed.

9.90 There are two Internet leaflets - an 'Internet Safety Guide for Parents' and a similar 'Safety Guide for Young Children' which provide useful information, particularly the 5 Smart Safety Tips.

9.91 The issues about being careful online apply equally to mobile phones. It is important to encourage children not to give out their mobile numbers to strangers or people they cannot trust completely.

9.92 Investigations should be carried out with regard to the Joint Protocol.



Chapter 10

Management and use of Information Concerning Known and Suspected Offenders against Children

CHAPTER 10 MANAGEMENT AND USE OF INFORMATION CONCERNING KNOWN AND SUSPECTED OFFENDERS AGAINST CHILDREN

10.1 Although the focus of the work of HSS Trusts and allied agencies is primarily on children, safeguarding children requires attention to be paid to the individuals who may abuse them. Part of protecting children may be the use and disclosure of information to other agencies and third parties.

10.2 There are various situations within which professionals may have to decide whether it is appropriate to disclose to a third party information held about an individual who is suspected of being a risk to children. All such decisions must be taken on the basis of all available information and with the full understanding of the implications for such disclosure.

10.3 It is recognised that there are particular concerns in relation to sharing information about people who are suspected, but not convicted, of serious offences against children. Information concerning known or suspected offenders against children will be held by many agencies, e.g. GPs, Health Visitors, Police, Education staff and Social Services.

This guidance also relates to individuals who have not been convicted or cautioned for offences, but who are suspected of involvement in the abuse of children.

10.4 Disclosure of information about those who abuse children raises some very sensitive and far-reaching issues. The decision to share information needs to be based on a clear assessment of risk, in line with Chapters 3 and 5 of these Procedures. Where there is a conflict of interest between protecting the rights of the individual and the protection of children the protection of children **must be the paramount consideration.** The Police and other relevant agencies should judge each case on its merits, taking account of the degree of risk.

10.5 Safeguarding children depends upon effective information, collaboration and understanding among families, agencies and professionals. Constructive relationships between individual workers and agencies need to be supported by a strong lead from senior management within each agency.

10.6 In addition to these policies and procedures the framework for the sharing of information about those who pose a risk to children is found in:

- Chapter 8 of 'Co-operating to Safeguard Children'
- MASRAM Practice Guidance
- HPSS Circular 3/96.

10.7 Where it is believed that a known or suspected offender against children is having contact with a specific child then the procedures outlined in Chapter 5 should be followed. The child may be related to the offender, resident within the same household or simply have contact through visiting the household or living within the community.

Risk Assessment and Management – Physical and Emotional Abuse and Neglect

10.8 Paragraphs 10.8 – 10.12 apply only to non-sexual abuse cases and aim to cover those situations where significant harm or the likelihood of significant harm to a child prompts risk assessment and risk management procedures to avoid further abuse. It applies to those who are convicted of a scheduled offence[10] against a child or those who pose a risk of harm to a child in a family or in the community, and includes both males and females.

10.9 Where there are suspicions or concerns that a child is in contact with, or likely to be in contact with, a person who is known or suspected to have inflicted abuse on a child or has a record of offences of violence which may cause concern for the child's safety, the person identifying the risk should discuss his concern with a senior colleague/line manager to clarify the potential for a child to be considered at risk.

10.10 A Risk Assessment and Management Meeting can be convened by any of the agencies listed in Paragraph 7.9 of 'Co-operating to Safeguard'. It may be necessary following a Case Conference; when a non-custodial sentence is imposed; where there are general concerns about an individual in the community; or when an offender is released from custody or prison.

[10] See Schedule 1 (as amended) of the Children and Young Persons (Northern Ireland) Act 1968 for a list of relevant offences

10.11 Where the concerns relate to a specific child, Social Services must be informed and should take the lead role in convening a Risk Assessment and Management Meeting.

10.12 The procedure outlined in Paragraph 7.12 in 'Co-operating to Safeguard Children' should be followed. In addition, where the concerns relate to a specific child, the following procedure should be followed:

- where agreed at the Risk Assessment and Management Meeting the Trust Social Work Manager will invite the alleged or known abuser to the local Social Services office to discuss the reported concern
- his response will be reported to the members of the Risk Assessment and Management Meeting who must decide whether the information given by the suspected or known abuser constitutes a risk to any child with whom he has contact
- where it is considered such a risk exists, the child's parent must be given information in order to protect their child from harm
- when appropriate, the suspected or known abuser should be encouraged to discuss the concerns with the parent of the child in the presence of a social worker
- when this is not appropriate, the social worker will make the parent of the child aware of the concerns, preferably in the presence of the suspected or known abuser, but if necessary, independently
- at this stage, if the child's parent appears to understand the risk and provides evidence regarding how he is able to protect his child, there may be no need to take further action
- if it is believed that there is a risk, however, child protection procedures as detailed in Chapters 5 & 6 of these Procedures must be implemented
- consideration should always be given to whether it will be necessary to take legal action to protect the child.

Multi-Agency Sex Offender Risk Assessment and Management (MASRAM)

10.13 The purpose of the multi-agency procedures for the assessment and management of sex offenders (MASRAM) is to provide guidance and a framework to help the Police, Social Services, Probation Services, Prison Services and other relevant agencies in the statutory, community, and voluntary sectors to work together on the risk assessment and risk management of those convicted of sex offences or, in certain circumstances, thought to pose a risk of sexual harm to children. This includes both males and females.

Common Terminology and Categories

10.14 There are a number of categories of individual to whom these procedures should be applied to:

- **A Suspected Sex Offender** is a person who is not convicted but who is considered to pose a significant risk to children or adults in the opinion of a Case Conference or risk assessment meeting.
- **A Non-registered Sex Offender** is an offender who has previous convictions or police cautions for an offence(s) that would have resulted in registration if the Sex Offenders Act 1997 (as amended by the Sexual Offences Act 2003) had been in force at the time of conviction. It may also apply to an individual who has completed his period of registration.
- **A Registered Sex Offender** is an offender who has been convicted or cautioned by the Police since 1 September 1997 for an offence listed in schedule 1 of the Sex Offenders Act 1997 (which has been replaced by Schedule 2 of the Sex Offences Act 2003); was found not guilty by reason of insanity or found unfit to plead in respect of a relevant offence; or who was at that point either serving a sentence for such an offence or was detained under a Hospital Order (with or without restrictions) or a patient subject to a guardianship.

10.15 Where there are suspicions or concerns that a child is in contact with/or likely to be in contact with a person who is convicted or suspected of sexually abusing a child, the person identifying the risk should discuss their concern with a senior colleague/line manager. The procedure as detailed in MASRAM guidance should

be followed along with the steps outlined below which should be followed:

- a referral should be made to Social Services in the area in which the child lives
- on receipt of the referral Social Services will carry out the actions outlined in Chapters 3 and 5 of these Procedures
- Social Services should instigate checks with the Trust representative of the Area Sex Offender Risk Management Committee (ASORMC) as to whether the individual concerned has been, or is currently, subject to the MASRAM process
- the suspected/known abuser should be informed in advance of the checks unless there are reasons concerning the needs of the child for not doing so
- if the alleged abuser is, or has been subject to the MASRAM process, an urgent referral should be made by the team leader (Social Services), to the ASORMC for discussion at their next meeting
- if the suspected abuser is not known to the MASRAM process, the Trust social work manager should instigate checks with the Police Care Unit and Probation Service to obtain further information about the cause for concern/allegation and, if the information indicates that an individual may pose a risk to a child, set up a Risk Assessment and Management Meeting chaired by a senior officer from Social Services, at the level of Social Worker Manager (APSW equilivent or above)
- the purpose of the meeting is to share information, assess the risk to the child and agree actions to be taken, to include affording the suspected abuser an opportunity to express his views regarding the concerns
- where agreed at the meeting the team leader will invite the suspected/known abuser to the local social services office to discuss the reported concern and report back to the members of the meeting
- members of this meeting must decide whether the information given by the suspected/known abuser constitutes a risk to any child with whom he has contact

- where it is considered such a risk exists, the child's parent must be given the information in order to protect his child from harm
- initially, the suspected/known abuser should be encouraged to discuss the concerns with the parent of the child in the presence of a social worker
- when the suspected/known abuser is unwilling to take such action, the social worker will make the parent of the child aware of the concerns, preferably in the presence of the alleged or known abuser, but if necessary independently
- at this stage, if the child's parents appears to understand the risk and provides evidence regarding how he is able to protect his child, there may be no need to take further action
- if it is believed that there is a risk, however, a Child Protection Case Conference must be called to consider the issues from the child's perspective
- consideration should always be given to whether it will be necessary to take legal action to protect the child.

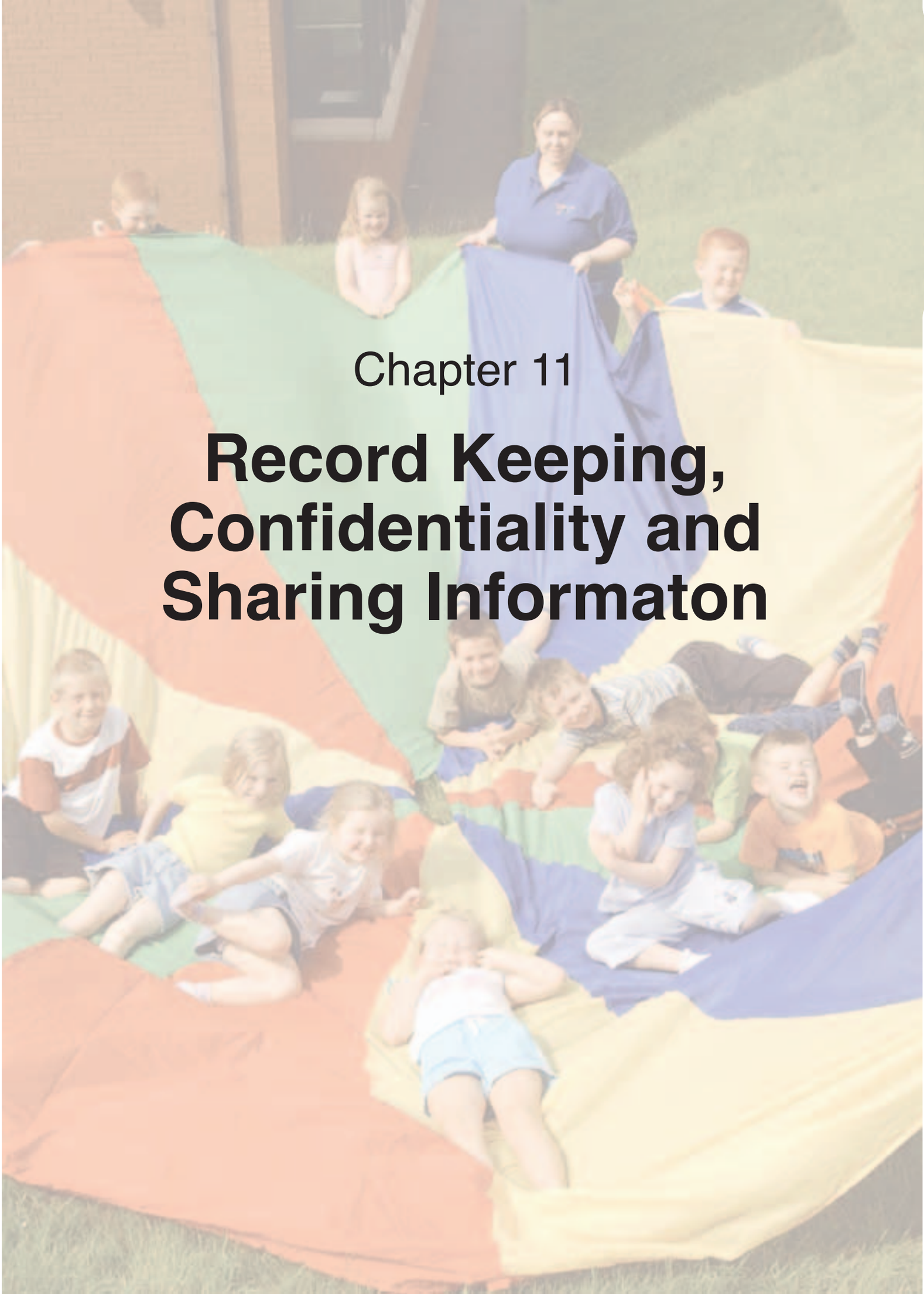
10.16 Staff from all agencies should be alert to current case law decisions on the sharing of information. Examples are cited in paragraph 7.4 of "Co-operating to Safeguard Children".

Adults thought to pose a risk of Sexual Harm to Children who are not Convicted of Offences or Subject to Sex Offender Registration Requirements

10.17 Where any agency has a concern that an individual's behaviour may meet the criteria for a Risk of Sexual Harm Order (RSHO) (as set out in Part 2 of the Sexual Offences Act 2003), representation should be made to the PSNI MASRAM Unit[11]. Where it is agreed by PSNI that the criteria for an RSHO may be met, the individual and the risk he poses will be considered at the relevant ASORMC. The ASORMC will consider an RSHO application by PSNI as well as any future involvement in the MASRAM procedures.

An RSHO is a civil order that can be applied for by the Chief Constable against any individual person aged 18 or over thought to pose a sexual risk to children aged under 17. Courts can impose conditions in an RSHO and it brings with it registration requirements.

[11] See NISOSMC MARAM Practice Guidance



Chapter 11

Record Keeping, Confidentiality and Sharing Informaton

CHAPTER 11 RECORD KEEPING, CONFIDENTIALITY AND SHARING INFORMATION

Record Keeping

11.1 Good record-keeping is an essential part of a professional's responsibility and is vital to good child protection practice. It helps to focus child protection work and is important to working across agency and professional boundaries.

11.2 The subject of a record has the right in law to request access to all information kept about him by any agency. There are exemptions to this, however, and some information, e.g. relating to other people, may be withheld. Records may be required to be disclosed in court proceedings.

11.3 Clear and accurate records are vital in:

- ensuring that there is documented evidence of involvement with a child and/or family
- helping with continuity when individual workers are not available or move
- providing a tool for monitoring work
- the sourcing of evidence for investigation and inquiries.

11.4 Records should be written contemporaneously and must:

- provide the chronology of the case
- use clear, straight forward language
- avoid abbreviations and jargon
- be concise yet sufficiently comprehensive
- be accurate
- differentiate among fact, opinion, judgement and hypothesis
- be accessible
- clearly show the decisions taken by each agency and across agencies
- be legible
- be legibly signed and dated by the worker and appropriate manager if required.

11.5 Records should reflect the facts of the case and the professional analysis of the information available. Reports should include the following:

- the relevant history of the child and family which led to the intervention
- the identification of significant harm or potential significant harm
- those at risk and the source of the harm
- how decisions and actions were agreed and by whom in each agency or profession and across agencies/professions
- the intervention to be taken by each agency and/or professional and the intended outcomes
- the evidence that the outcomes have been achieved and change has taken place
- an analysis of the progress that is being made
- the assessment process
- that all statutory and procedural requirements have been met.

11.6 Each agency should ensure that:

- records are kept up-to-date
- relevant changes in circumstances are shared with other key agencies
- when a child moves from their area of responsibility a written summary of their involvement with the child is forwarded within **5 working days** to the relevant agency in the child's new area
- records are stored safely and can be retrieved promptly.

11.7 Relevant information about a child and family who are the subject of child protection concerns will normally be collated in one place by Social Services.

Record Retention and Destruction

11.8 All agencies must have a policy for the retention and destruction of child protection records. This policy must be consistent with legislative requirements and good practice. This policy must clearly indicate:

- which records will be retained
- how long records will be held
- the purpose and format of retained records
- how records will be retained, with particular emphasis on security
- how records will be accessed, who has the responsibility for controlling access and levels of access
- the arrangements for the destruction of records.

11.9 When agencies have off-site storage arrangements that are managed by another organisation, they must ensure that the storage and access arrangements are safe and secure and meet legislative requirements.

Individual Agency Records

11.10 Staff from individual agencies will maintain their own records of work with child protection cases. These records will be subject to each agency's arrangements for maintaining confidentiality and allowing client-access.

11.11 Each agency should have a policy stating the purpose and format for keeping records.

11.12 Individual agencies should also give clear guidance to staff for transfer of relevant records relating to child protection cases when a registered child moves to another Health and Social Services Trust area.

Child Protection Records

11.13 These records include those relating to:

- the Child Protection Register
- Child Protection Case Conferences
- Child abuse investigations
- investigations into abuse by professionals.

11.14 They may contain information from more than one agency about both individual clients and other people. The agreed ACPC

procedures to safeguard these records are set out below and should be followed by all agencies.

11.15 The minimum acceptable standard of security for Case Conference minutes is a lockable filing cabinet with access restricted to those in the agency with a 'need to know' basis.

Destruction of Records

a) Enquiries to the Child Protection Register

11.16 Records of enquiries to the Child Protection Register are placed on the child's file and destroyed with the file in accordance with the Trust's procedures.

b) Non-Registration

11.17 Minutes of Child Protection Case Conferences where the child's name was not placed on the Child Protection Register must be destroyed by Case Conference participants once they have been read and checked for accuracy.

11.18 One copy of the minutes will be retained on the child's file by Social Services, and be destroyed along with the file in accordance with the Trust's destruction of records policy.

c) Registration

11.19 Minutes of the Case Conference where the child's name is placed on the Child Protection Register should be put on the file of each agency attending the conference. The file should be kept in approved secure conditions in accordance with the agency's policy.

11.20 All minutes must be destroyed by the agency at the time the child's name is removed from the Register, unless there is an agency policy for destruction of files, in which case the minutes will be destroyed along with the file.

d) Records of Investigation

11.21 Records of investigations into alleged abuse which are not substantiated would normally be held on the child's file by Social Services and destroyed in accordance with the Trust's destruction policy.

e) Records of allegations of abuse by foster-parents

11.22 Records of investigations into allegations that a foster-parent has abused a child in his care will be kept, together with the reports of any Case Conferences and final recommendations, by the Register Custodian. These records are kept separate from other Child Protection Register records.

11.23 A further complete copy will be kept within the file of the foster-parent, to be destroyed in accordance with the destruction policy for foster-parent files.

11.24 All other records will be destroyed.

f) Records of allegations of abuse by professionals.

11.25 Records of investigations into allegations of abuse of a child by a professional will be kept by the Register Custodian, together with the reports of any Case Conferences and final recommendations. These records will be kept separate from other Child Protection Register records.

11.26 One further copy may be kept by the employing agency.

11.27 All other records will be destroyed.

11.28 Retention of records by the Register Custodian is subject to the following safeguards:

- child protection register records will be accessed only when there is a subsequent enquiry regarding possible abuse of the named child, a sibling of the named child, or a child who is a member of the same household as the named child
- in the case of records pertaining to a foster-parent or a professional, these records would be accessed only if there was a subsequent allegation regarding alleged abuse by that person
- access to records is available only through the Register Custodian.

Confidentiality & Sharing Information

11.29 Research, experience and the outcome of inquiries into child abuse have shown repeatedly that safeguarding children requires professionals and others to share information about:

- a child's health, development and exposure to possible harm
- a parent who may need help, or may not be able to care for a child adequately and safely
- those who may pose a risk of harm to a child
- children who may present a risk to other children.

Often, it is only when information from a number of sources has been shared that it becomes clear that a child is, or is not, at risk of suffering significant harm.

11.30 Those providing services to adults and children will have concerns about the need to balance their duties towards their client/patient and to protect children from harm. Some professionals may be supporting and providing services to more than one family member. Where there are concerns that a child is, or may be, at risk of significant harm, the overriding objective must be to safeguard the child.

11.31 At all stages of the child protection process professionals must be prepared to share the information necessary to keep a child from harm. They must not disclose information for any other purpose without the permission of the person who provided it, unless the safety of the child requires this.

11.32 The following guidance refers to sharing oral, written or electronic forms of information.

Principles

11.33 The key principles for sharing information are:

- the sharing of appropriate information in order to safeguard a child
- the commitment to working together
- personal information about children and families held by agencies is subject to a duty of confidence

- wherever possible, consent should be sought from the child and/or parent to share information with a third party
- agencies should have clear and secure arrangements for sharing accurate and up-to-date information
- there must be a clear purpose for sharing information between professionals
- the needs of the child override the parent's refusal of consent to share information.

Transmission of Personal Data by Electronic Communication

11.34 Electronic communication systems such as fax and e-mail are now widely used to share information between and within organisations. Whilst this allows speedier communication it also poses risks.

11.35 Electronic communication systems should not be used for the routine transmission of personal data. They may be appropriate in the following circumstances, however:

- in an emergency situation where the life or welfare of a client or patient is at risk
- in other situations where there is no alternative means available to transfer personal information
- in urgent, but non-emergency, situations where the use of electronic communication would provide demonstrable benefits for the client or patient. These should be few and monitored to ensure they do not become routine.

11.36 The use of electronic communication should be authorised by a senior professional manager. Administrative staff cannot authorise its use.

11.37 There must be appropriate arrangements with security of personal information when it is stored, sent or received by fax, e-mail or other electronic means. Fax machines and computer terminals must be in secure areas.

a) Fax Machines

11.38 The use of fax machines enables speedy communication between agencies. While this has created opportunities it also poses risks to the confidentiality and security of information over and above those that apply to routine paper transactions by mail.
The additional risks are:

- information could be sent to the wrong location if the fax-operator mis-dials the number of the receiving fax, though the use of preset buttons can largely overcome this
- even if the number is correctly dialled, the data could be mis-directed due to an error with the exchange equipment
- fax machines are often shared by several departments and may be located in open areas with unrestricted access
- fax machines may also be left unattended
- fax messages are not received in an enveloped form and can be read by anyone who comes in contact with them, which may be in breach of the "need to know" principle.

11.39 For the reasons outlined above, fax machines should not be used for the routine transmission of personal data. This includes the faxing of personal information directly from personal computers.

11.40 Fax machines may be used for transmission of personal data in the situations outlined above only if one of the following procedures is observed. This guidance is in addition, not a replacement for, the normal rules governing disclosure of personal data.

11.41 **Method 1**

1 The operator sending the fax contacts the receiving organisation to confirm the correct fax number and that the fax is manned and to inform them that a fax containing personal details is about to be transmitted.

2 Once the operator sending the fax has established voice contact with the operator manning the receiving fax machine, the sender keys the number of the receiving fax and establishes that contact has been made with the appropriate fax machine by sending two pages of headed note paper.

3 Once the receiving operator confirms that the headers have

been received then the message containing the personal details is sent. Telephone contact with the receiving operator may be ended at this point.

4 If the header pages are not received the sending operator will discontinue the transmission and repeat step 1.

This procedure ensures that the fax machine is under supervision and that the correct fax machine has been connected.

11.42 **Method 2**

1 Operator telephones receiving organisation advising them of the client's/patient's personal details i.e. name, address etc.

2 The fax is sent with the aforementioned details deleted i.e. the data remains anonymous during transmission.

3 Recipient matches personal data to the transmitted material.

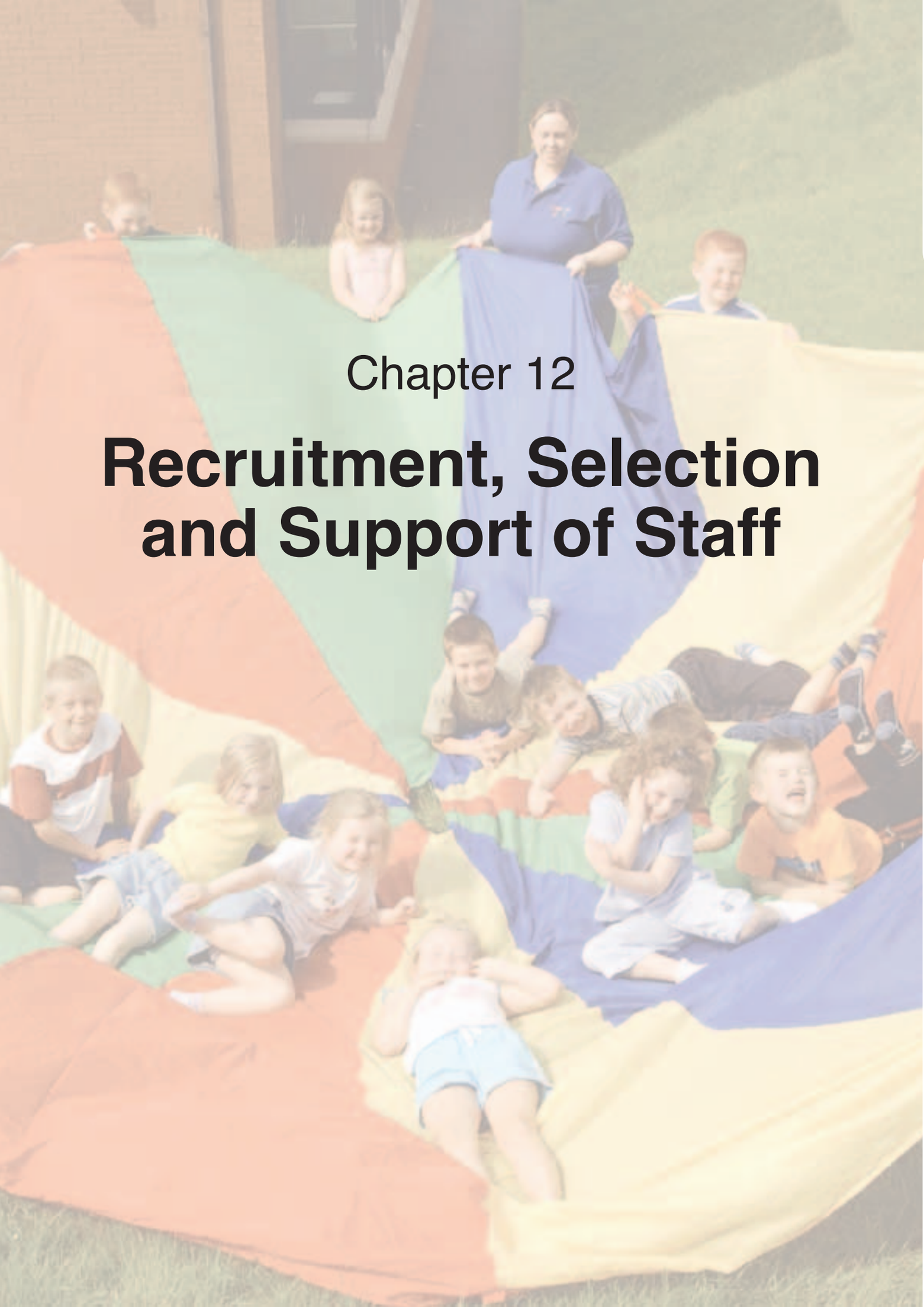
It is emphasised that these procedures **are not for the routine transmission of personal and confidential data**

b) E-mail

11.43 The growth of technology offers greater ability to move confidential documents between agencies and within organisations. There must be a recognition of the confidential nature of Child Protection information sent through e-mail and users must ensure that passwords are confidential to restrict access and maintain confidentiality.

11.44 Within the HPSS data sent internally via the intranet may be treated as secure but it should be noted that information sent by e-mail externally to the HPSS through the internet may be intercepted.

11.45 Sensitive data sent over the internet must be encrypted and the recipient notified of the password by an alternative means e.g. by telephone. This **must not** be done by e-mail.



Chapter 12

Recruitment, Selection and Support of Staff

CHAPTER 12 RECRUITMENT, SELECTION AND SUPPORT OF STAFF

12.1 All agencies and organisations where staff, volunteers or foster carers work closely with children should have policies and procedures in place to ensure that they engage those who are most suitable to work with children. Guidance is available from a number of sources (refer to 'Co-operating to Safeguard Children' 9.1).

The Pre-Employment Consultancy Service

12.2 The Pre-Employment Consultancy Service (PECS) is operated by the Department of Health, Social Services and Public Safety and was established to help organisations working with children (or adults with a learning disability) to make the right choices when appointing staff or volunteers. It is designed to provide an additional safeguard which complements and strengthens staff recruitment and selection procedures. PECS should never be relied upon to screen out all those who may harm children and its use should not be at the expense of good employment practices. PECS provides a means of accessing any information held by the Police, the Department of Health, Social Services and Public Safety and the Department of Education, which might have a bearing on an individual's suitability.

12.3 PECS is available to any statutory, voluntary, community or private sector organisation working with children within Northern Ireland. Any organisation wishing to use PECS must first apply to use the service by writing to the Child Care Policy Unit, Department of Health and Social Services.

12.4 'The Protection of Children and Vulnerable Adults (Northern Ireland) Order (2003)', establishes the statutory 'Disqualification from Working with Children List' kept by the DHSSPS. The Order places a legal requirement on child care organisations to both carry out pre-employment checking of staff, and report those dismissed, moved, suspended etc. for harming children. Non-child care organisations who become "accredited" by the DHSSPS under the Order will acquire identical legal responsibilities. The changes will be covered in guidance which will be issued by the Department of Health, Social Services and Public Safety (see the 'Protection of Children and Vulnerable Adults Order' Information Notes 1, 2 and 3 DHSSPS).

Managerial Responsibility

12.5 Managers in all agencies are responsible for providing the most effective practice within the resources available.

12.6 In the case of Social Services, it is the responsibility of managers to ensure that decisions arising from supervision are recorded on the child's case file.

12.7 An organisation must ensure that there is a process to provide and monitor managerial and professional knowledge and expertise. Consideration should be given to the use of external consultants and trainers if the knowledge and expertise is not available within the agency.

12.8 To support staff all managers should:

- recognise the stressful nature of child protection work
- provide support, control and guidance
- ensure there are appropriate written policies, procedures and good practice guidelines
- ensure staff have the necessary skills, knowledge and experience to undertake the work
- keep their own knowledge about child protection up-to-date in order to support staff in making appropriate decisions
- ensure all managers are trained for their work
- monitor and evaluate workloads to avoid overload of individual staff and/or teams
- have appropriate mechanisms in place to ensure staff safety
- have effective systems for collecting and analysing information on child protection services.

Supervision and Support

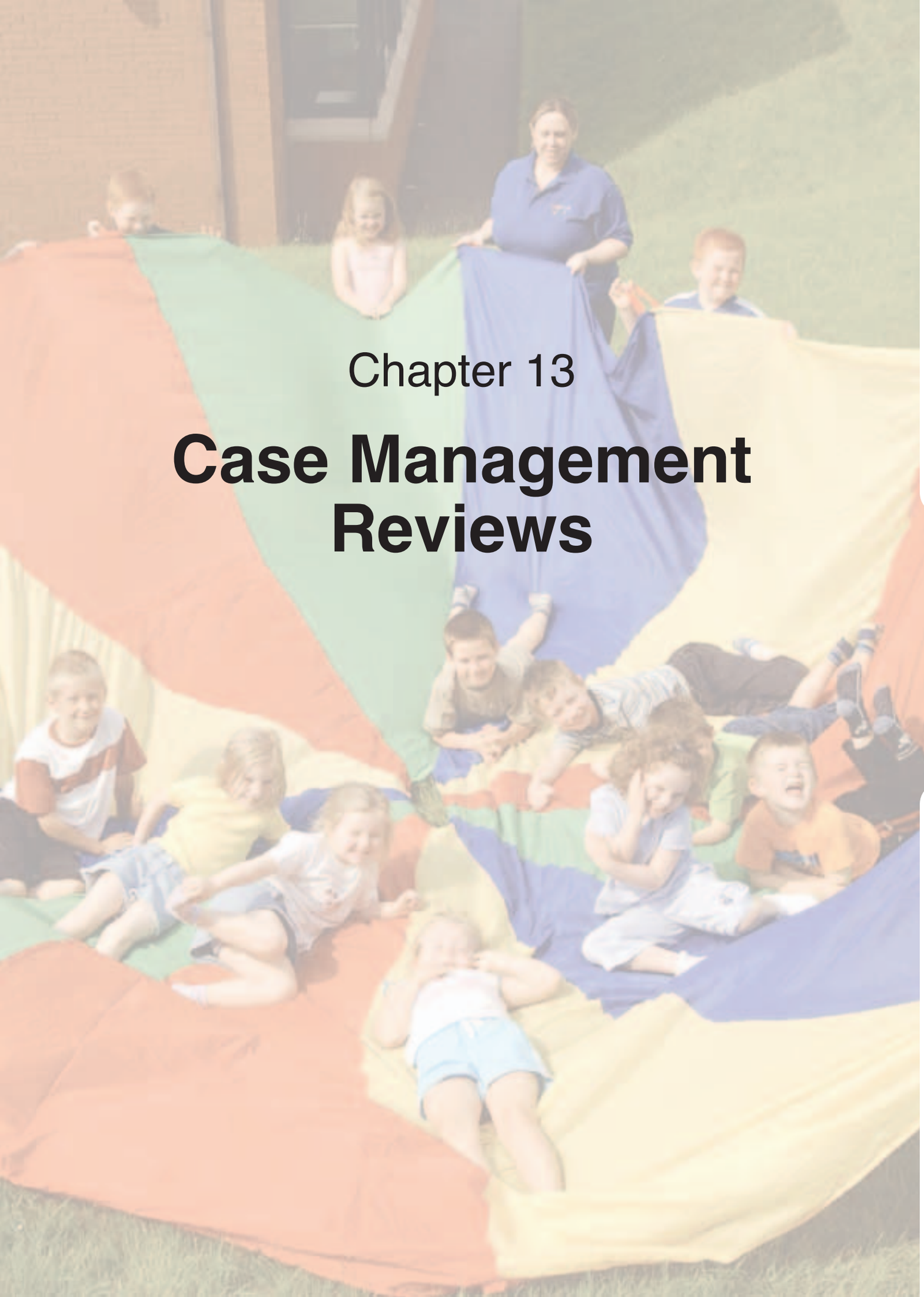
12.9 Child Protection work involves making difficult judgements. It is demanding work that can be stressful. All those involved must have access to supervision and support from managers on a frequent and regular basis in accordance with Agency policy and procedures. Social Work managers must provide formal supervision on a monthly basis as a minimum, to staff.

12.10 Whilst the ACPC recognises that supervision of Child Protection work varies according to organisational arrangement, each agency represented on the ACPC must have in place a policy for the formal supervision and management of Child Protection cases.

12.11 Those in a supervisory position should:

- scrutinise and evaluate the work carried out
- assess the strengths and weaknesses of the practitioner
- provide professional development and pastoral support
- identify the individual's training and development needs and develop training plans to meet those needs
- help to ensure that practice is soundly based and consistent with ACPC procedures.

12.12 Child Protection files must be seen and signed by the Social Work Manager for the Family and Child Care Team and the Social Work Manager is responsible for reviewing a representative sample of cases in preparation for supervision sessions, and to sign and date the file to indicate that such a review has taken place.



Chapter 13

Case Management Reviews

CHAPTER 13 CASE MANAGEMENT REVIEWS

13.1 An ACPC should always undertake a Case Management Review when:

- a child dies, including death by suicide, and abuse or neglect is known or suspected to be a factor in the child's death.

13.2 An ACPC should always consider whether to undertake a Case Management Review where:

- a child has sustained a potentially life threatening injury through abuse (including sexual abuse) or neglect
- a child has sustained serious and permanent impairment of health or development through abuse or neglect
- the case gives rise to concerns about the way in which local professionals and services worked together to safeguard children.

13.3 The purpose of Case Management Reviews is to:

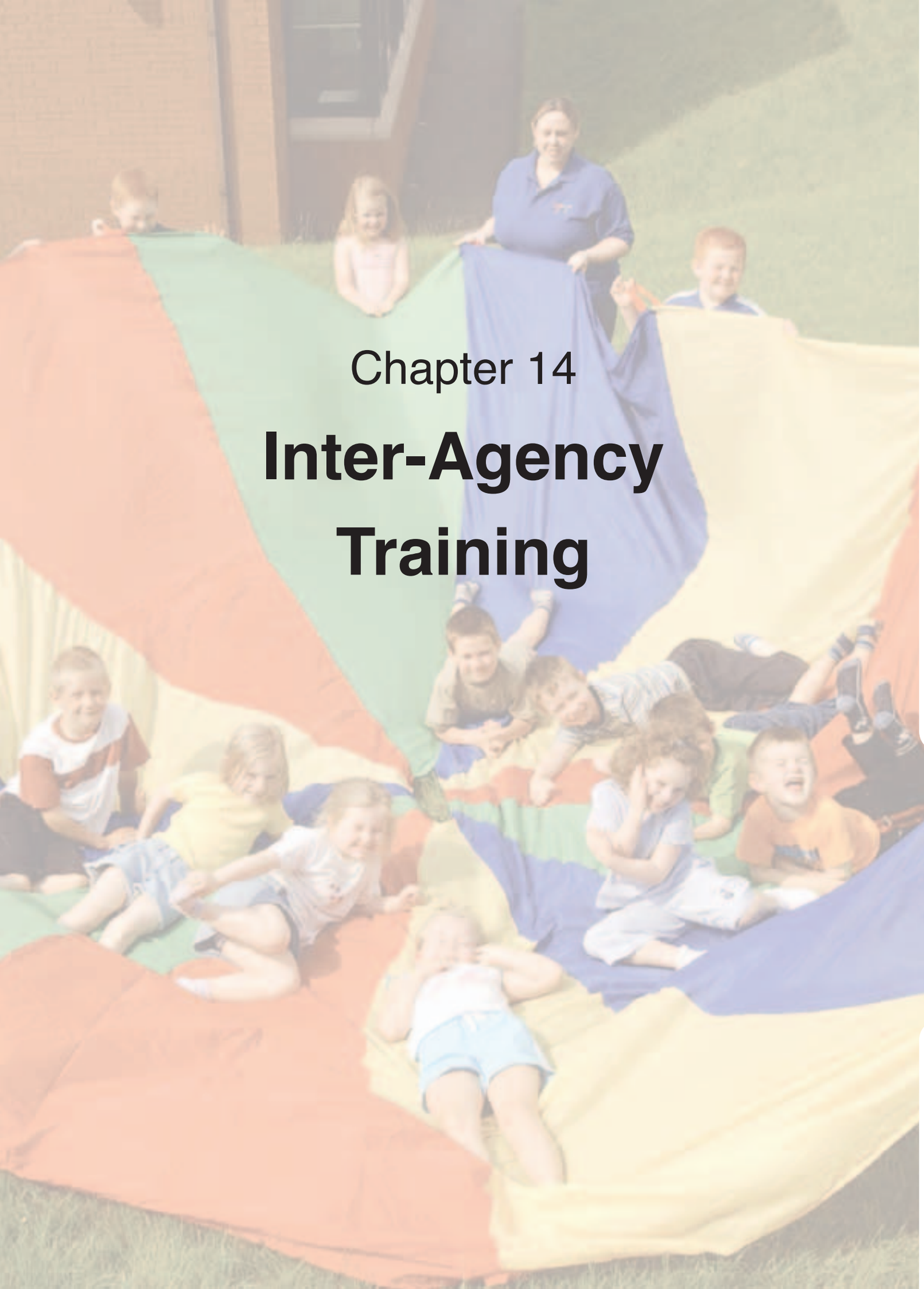
- establish the facts of the case
- establish whether there are lessons to be learned from the case about the way in which professionals and statutory and/or voluntary agencies work together to safeguard children
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence
- improve inter-agency working and thus provide better safeguards for children.

13.4 The review should be conducted in such a way that the process is a learning exercise. Case Management Reviews are not enquiries into how a child died or who was culpable. These are a matter for the Coroner and criminal courts respectively, to determine as appropriate.

13.5 Chapter 10 of 'Co-operating to Safeguard Children' should be consulted on the purpose and conduct of a Case Management Review and the action to be taken following the completion of a Case Management Review Report.

13.6 Consideration should be given to undertake a Case Management Review in the case of a sudden unexplained child death[12].

12 A regional policy on 'Sudden Unexplained Child Death' is currently being drawn up.



Chapter 14

Inter-Agency Training

CHAPTER 14 INTER-AGENCY TRAINING

Introduction

14.1 Effective child protection depends on the knowledge and judgement of all staff working directly with children and those who provide guidance, supervision and direction. It is important, therefore, that staff in direct contact with children and those in supervisory and management positions receive relevant training.

14.2 The ACPC is responsible for taking a strategic overview of the planning, delivery and evaluation of the inter-agency training strategy required to promote effective practice.

14.3 Training should be tailored to meet the needs of different staff. In 'Co-operating to Safeguard Children' three levels of training are detailed to meet the needs of staff, based on their roles and responsibilities:

Stage One – Introduction to the safeguarding of children, having regular contact with children and/or parents

Stage Two – Foundation training for staff working with children and families where there may be a high risk of significant harm, but the staff are not involved directly in Child Protection services

Stage Three – Specialist training for staff directly involved in investigation, assessment and intervention to protect children considered to be at risk of significant harm.

Further details are included in Chapter 11 of 'Co-operating to Safeguard Children.'

Appendices

APPENDIX 1

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APPENDIX 2

SIGNS AND SYMPTOMS OF CHILD ABUSE

This section contains information for all professionals working with children and families and is not an exhaustive list. The following pages provide guidance only and should not be used as a checklist.

2.1 The first indication that a child is being abused may not necessarily be the presence of a severe injury. Concerns may become apparent in a number of ways e.g.

- by bruises or marks on a child's body
- by remarks made by a child, his parents or friends
- by overhearing conversation by the child, or his parents
- by observing that the child is either being made a scapegoat by or has a poor relationship/bond with his parents
- by a child having sexual knowledge or exhibiting sexualised behaviour which is unusual given his age and/or level of understanding
- by a child not thriving or developing at a rate which one would expect for his age and stage of development
- by the observation of a child's behaviour and changes in his behaviour
- by indications that the family is under stress and needs support in caring for their children
- by repeat visits to a general practitioner or hospital.

2.2 There may be a series of events which in themselves do not necessarily cause concern but are significant, if viewed together. Initially the incident may not seem serious but it should be remembered that prompt help to a family under stress may prevent minor abuse escalating into something more serious.

2.3 It is important to remember that abused children do not necessarily show fear or anxiety and may appear to have established a sound relationship with their abuser(s). Staff should familiarise themselves on 'attachment theory' and its implications for assessing the bond between parents and their children.

2.4 Suspicions should be raised by e.g.

- discrepancy between an injury and the explanation
- conflicting explanation, or no explanation, for an injury
- delay in seeking treatment for any health problem
- injuries of different ages
- history of previous concerns or injuries
- faltering growth (failure to thrive)
- parents show little, or no, concern about the child's condition or show little warmth or empathy with the child
- evidence of domestic violence
- parents with mental health difficulties, particularly of a psychotic nature
- evidence of parental substance abuse.

2.5 *Signs and symptoms are indicators and simply highlight the need for further investigation and assessment.*

Parental Response to Allegations of Child Abuse which Raise Concern

2.6 Parents' responses to allegations of abuse of their child are very varied. The following types of response are of concern:

- there may be an unequivocal denial of abuse and possible non-compliance with enquiries
- parents may over-react, either aggressively or defensively, to a suggestion that they may be responsible for harm to their child
- there may be reluctance to give information, or the explanation given may be incompatible with the harm caused to the child, or explanations may change over time
- parents may display a lack of awareness that the child has suffered harm, or that their actions, or the actions of others, may have caused harm
- parents may seek to minimise the severity of the abuse, or not accept that their actions constitute abuse

- parents may fail to engage with professionals
- blame or responsibility for the harm may be inappropriately placed on the child or an unnamed third party
- parents may seek help on matters unrelated to the abuse or its causes (this may be to deflect attention away from the child and his injuries)
- the parents and/or child may go missing.

Physical Abuse

2.7 Children receive bumps and bruises as a result of the rough and tumble of normal play. Most children will have bruises or other injuries, therefore, from time to time. These will be accidental and can be easily explained.

2.8 It is not necessary to establish intent to cause harm to the child to conclude that the child has been subject to abuse. Physical abuse can occur through acts of both commission and/or omission.

2.9 Insignificant but repeated injuries, however minor, may be symptomatic of a family in crisis and, if no action is taken, the child may be further injured. All injuries should be noted and collated in the child's records and analysed to assess if the child requires to be safeguarded.

2.10 If on initial examination the injury is not felt to be compatible with the explanation given or suggests abuse, it should be discussed with a senior paediatrician.

2.11 A small number of children suffer from rare conditions, e.g. haemophilia or brittle bone disease, which makes them susceptible to bruising and fractures. It is important to remain aware, however, that in such children some injuries may have a non-accidental cause. A "clotting screen" only excludes the common conditions which may cause spontaneous bleeding. If the history suggests a bleeding disorder, referral to a haematologist will be required.

Recognition of Physical Abuse

a) Bruises + Soft Tissue Injuries

2.12 Common sites for accidental bruising depend on the developmental stage of the child. They include:

- forehead
- crown of head
- bony spinal protuberances
- elbows and below
- hips
- hands
- shins.

2.13 Less common sites for accidental bruising include:

- eyes
- ears
- cheeks
- mouth
- neck
- shoulders
- chest
- upper and inner arms
- stomach
- genitals
- upper and inner thighs
- lower back and buttocks
- upper lip and frenulum
- back of the hands.

2.14 Non-accidental bruises may be:

- frequent
- patterned, e.g. finger and thumb marks
- in unusual positions, (note developmental level and activity of the child).

Research on aging of bruises (from photographs) has shown that it is impossible to accurately age bruises although it can be concluded that a bruise with a yellow colour is more than 18 hours old. Tender or swollen bruises are more likely to be fresh. It is not possible to conclude definitely that bruises of different colours were sustained at different times. The following should give rise to concern e.g.

- bruising in a non-mobile child, in the absence of an adequate explanation
- bruises other than at the common sites of accidental injury for a child of that developmental stage
- facial bruising, particularly around the eyes, cheeks, mouth or ears, especially in very young children
- soft tissue bruising, on e.g. cheeks, arms and inner surface of thighs, with no adequate explanation
- a torn upper lip frenulum (skin which joins the lip and gum)
- patterned bruising e.g. linear or outline bruising, hand marks (due to grab, slap or pinch – may be petechial), strap marks particularly on the buttocks or back
- ligature marks caused by tying up or strangulation.

2.15 Most falls or accidents produce one bruise on a single surface, usually a bony protuberance. A child who falls downstairs would generally only have one or two bruises. Children usually fall forwards and therefore bruising is most usually found on the front of the body. In addition there may be marks on their hands if they have tried to break their fall.

2.16 Bruising may be difficult to see on a dark skinned child. Mongolian blue spots are natural pigmentation to the skin, which may be mistaken for bruising. These purplish-blue skin markings are most commonly found on the backs of children whose parents are darker skinned.

b) Eye Injuries

2.17 Injuries which should give cause for concern:

- black eyes can occur from any direct injury, both accidental and non-accidental. Determining how the injury occurred is vital, therefore; bilateral “black eyes” can occur accidentally as a result of blood tracking from a very hard blow to the central forehead (Injury should be evident on mid-forehead, bridge of nose). It is rare for both eyes to be bruised separately, accidentally however and at the same time
- subconjunctival haemorrhage
- retinal haemorrhage.

c) Burns and Scalds

2.18 Accidental scalds often:-

- are on the upper part of the body
- are on a convex (curved) surface
- are irregular
- are superficial
- leave a recognisable pattern.

2.19 It can be difficult to distinguish between accidental and non-accidental burns. Any burn or scald with a clear outline should be regarded with suspicion e.g.

- circular burns
- linear burns
- burns of uniform depth over a large area
- friction burns
- scalds that have a line which could indicate immersion or poured liquid
- splash marks
- old scars indicating previous burns or scalds.

2.20 When a child presents with a burn or scald it is important to remember:

- a responsible adult checks the temperature of the bath before a child gets in to it
- a child is unlikely to sit down voluntarily in too hot water and cannot accidentally scald his bottom without also scalding his feet
- "doughnut" shaped burns to the buttocks often indicate that a child has been held down in hot water, with the buttocks held against the water container e.g. bath, sink etc.
- a child getting into too hot water of its own accord will struggle to get out and there are likely to be splash marks
- small round burns may be cigarette burns, but can often be confused with skin conditions. Where there is doubt, a medical/dermatology opinion should be sought.

d) Fractures

2.21 The potential for a fracture should be considered if there is pain, swelling and discoloration over a bone or joint or a child is not using a limb, especially in younger children. The majority of fractures normally cause pain and it is very difficult for a parent to be unaware that a child has been hurt. In infants, rib and metaphyseal limb fractures may produce no detectable ongoing pain however. Caution is required, therefore, before concluding that a reasonable carer should have known that something was wrong with an infant who has such fractures.

2.22 It is very rare for a child aged under one year to sustain a fracture accidentally, but there may be some underlying medical condition, e.g. brittle bone disease, which can cause fractures in babies.

2.23 The most common non-accidental fractures are to the long bones in the arms and legs and to the ribs. The following should give cause for concern and further investigation may be necessary:

- any fracture in a child under one year of age
- any skull fracture in children under three years of age
- a history of previous skeletal injuries which may suggest abuse

- skeletal injuries at different stages of healing
- evidence of previous fractures which were left untreated.

e) Scars

2.24 Children may have scars from previous injuries. Particular note should be taken if there is a large number of scars of different ages, or of unusual shapes or large scars from burns or lacerations that have not received medical treatment.

f) Bites

2.25 Bites are always non-accidental in origin; they can be caused by animals or human beings (adult/child); a dental surgeon with forensic experience may be needed to secure detailed evidence in such cases.

g) Other Types of Physical Injuries

2.26
- poisoning, either through acts of omission or commission
- ingestion of other damaging substances, e.g. bleach
- administration of drugs to children where they are not medically indicated or prescribed
- female genital mutilation, which is an offence, regardless of cultural reasons
- unexplained neurological signs and symptoms, e.g. subdural haematoma.

h) Fabricated or Induced Illness

2.27 Fabricated or induced illness, previously known as Munchausen's Syndrome by Proxy, is a condition where a child suffers harm through the deliberate action of the main carer, in most cases the mother, but which is attributed to another medical cause.

2.28 It is important not to confuse this deliberate activity with the behaviour and actions of over-anxious parents who constantly seek advice from doctors, health visitors and other health professionals about their child's wellbeing.

2.29 There is a need to exercise caution about attributing a child's illness, in the absence of a medical diagnosis, to deliberate activity

on the part of a parent or carer to a fabricated or induced illness, as stated in the Court of Appeal judgement in the case of Angela Cannings.
(R v Cannings (2004) EWCA Crim1 (19 January 2004)).

2.30 The following behaviours exhibited by parents can be associated with fabricated or induced illness:

- deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation
- interfering with treatments by over-dosing, not administering them or interfering with medical equipment such as infusion lines or not complying with professional advice, resulting in significant harm
- claiming the child has symptoms which may be unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits
- exaggerating symptoms, causing professionals to undertake investigations and treatments which may be invasive, unnecessary and, therefore, are harmful and possibly dangerous
- obtaining specialist treatments or equipment for children who do not require them
- alleging psychological illness in a child.

2.31 There are a number of presentations in which fabricated or induced illness may be a possibility. These are:

- failure to thrive/growth faltering (sometimes through deliberate withholding of food)
- fabrication of medical symptoms especially where there is no independent witness
- convulsions
- pyrexia (high temperature)
- cyanotic episode (reported blue tinge to the skin due to lack of oxygen)
- apnoea (stops breathing)

- allergies
- asthmatic attacks
- unexplained bleeding (especially anal or genital or bleeding from the ears)
- frequent unsubstantiated allegations of sexual abuse, especially when accompanied by demands for medical examinations
- frequent 'accidental' overdoses (especially in very young children).

2.32 Concerns may arise when:

- reported symptoms and signs found on examinations are not explained by any medical condition from which the child may be suffering
- physical examination and results of medical investigations do not explain reported symptoms and signs
- there is an inexplicably poor response to prescribed medication and other treatment
- new symptoms are reported on resolution of previous ones
- reported symptoms and/or clinical signs do not occur when the carers are absent
- over time the child is repeatedly presented to health professionals with a range of signs and symptoms
- the child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder or disability from which the child is known to suffer.

2.33 *It is important to note that the child may also have an illness that has been diagnosed and needs regular treatment. This may make the diagnosis of fabricated or induced illness difficult, as the presenting symptoms may be similar to those of the diagnosed illness.*

Sexual Abuse

2.34 Most child victims are sexually abused by someone they know, either a family member or someone well known to them or their family. In recent years there has been an increasing recognition that both male and female children and older children are sexually abused to a greater extent than had previously been realised.

2.35 There are no 'typical' sexually abusing families. Children who have been sexually abused are likely to have been put under considerable pressure not to reveal what has been happening to them. Sexual abuse is damaging to children, both in the short and long term.

2.36 Both boys and girls of all ages are abused and the abuse may continue for many years before it is disclosed. Abusers may be both male and female.

2.37 It is important to note that children and young people may also abuse other children sexually.

2.38 Children disclosing sexual abuse have the right to be listened to and to have their allegations taken seriously. Research shows it is rare for children to invent allegations of sexual abuse and that in fact they are more likely to claim they are not being abused when they are.

2.39 It is important that the indicators listed below are assessed in terms of significance and in the context of the child's life, before concluding that the child is, or has been, sexually abused. Some indicators take on a greater, or lesser, importance depending upon the child's age.

Recognition of Sexual Abuse

2.40 Sexual abuse often presents in an obscure way. Whilst some child victims have obvious genital injuries, a sexually transmitted infection or are pregnant, relatively few children are so easily diagnosed. The majority of children subjected to sexual abuse, even when penetration has occurred, have on medical examination no evidence of the abuse having occurred.

2.41 The following indicators of sexual abuse may be observed in a child. There may be occasions when no symptoms are present but

it is still thought that a child may be, or has been, sexually abused. Suspicions increase where several features are present together. **The following list is not exhaustive and should not be used as a check list.**

Pre-School Child (0-4 years)

2.42 Possible physical indicators in the pre-school aged child include:

- bruises, scratches, bite marks or other injuries to buttocks, lower abdomen or thighs
- itching, soreness, discharge or unexplained bleeding
- physical damage to genital area or mouth
- signs of sexually transmitted infections
- pain on urination
- semen in vagina, anus, external genitalia
- difficulty in walking or sitting
- torn, stained or bloody underclothes or evidence of clothing having been removed and replaced
- psychosomatic symptoms such as recurrent abdominal pain or headache.

2.43 Possible behavioural indicators include:

- unusual behaviour associated with the changing of nappy/underwear, e.g. fear of being touched/hurt, holding legs rigid and stiff or verbalisation like “stop hurting me”
- heightened genital awareness - touching, looking, verbal references to genitals, interest in other children’s or adults’ genitals
- using objects for masturbation - dolls, toys with phallic-like projections
- rubbing genital area on an adult - wanting to smell genital area of an adult, asking adult to touch or smell their genitals
- simulated sexual activity with another child e.g. replaying the sexually abusive event or wanting to touch other children etc
- simulated sexual activity with dolls, cuddly toys

- fear of being alone with adult persons of a specific sex, especially that of the suspected abuser
- self-mutilation e.g. picking at sores, sticking sharp objects in the vagina, head banging etc.
- social isolation - the child plays alone and withdraws into a private world
- inappropriate displays of affections between parent and child who behave more like lovers
- fear of going to bed and/or overdressing for bed
- child takes over 'the mothering role' in the family whether or not the mother is present.

Primary School Age Children

2.44 In addition to the above there may be other behaviour especially noticeable in school:

- poor peer group relationships and inability to make friends
- inability to concentrate, learning difficulties or a sudden drop in school performance
- reluctance to participate in physical activity or to change clothes for physical education, games or swimming
- unusual or bizarre sexual themes in child's art work or stories
- frequent absences from school that are justified by one parent only, apparently without regard for its implications for the child's school performance
- unusual reluctance or fear of going home after school.

The Adolescent

2.45 In addition to the physical indicators previously outlined in the pre-school and pre-adolescent child, the following indicators relate specifically to the adolescent:

- recurrent urinary tract infections
- pregnancy, especially where the information about or the identity of the father is vague or secret or where there is complete denial of the pregnancy by the girl and her family
- sexually transmitted infections.

2.46 Possible behavioural indicators include:

- repeated running away from home
- sleep problems - insomnia, recurrent nightmares, fear of going to bed or overdressing for bed
- dependence on alcohol or drugs
- suicide attempts and self-mutilation
- hysterical behaviour, depression, withdrawal, mood swings;
- vulnerability to sexual and emotional exploitation, fear of intimate relationships, promiscuity
- eating disorders – e.g. anorexia nervosa and bulimia
- low self-esteem and low expectation of others
- persistent stealing and /or lying
- sudden school problems - taunting, lack of concentration, falling standard or work etc
- fear or abhorrence of one particular individual.

Emotional Abuse

2.47 Emotional abuse is as damaging as other, visible, forms of abuse in terms of its impact on the child. There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to emotional abuse. Emotional abuse has an impact on a child's physical health, mental health, behaviour and self-esteem. It can be particularly damaging for children aged 0 to 3 years.

2.48 Emotional abuse may take the form of under-protection, and/or over-protection, of the child, which has a significant negative impact on a child's development.

2.49 The parents' physical care of the child, and his environment, may appear to meet the child's needs, but it is important to remain aware of the interactions and relationship which occur between the child and his parents to determine if they are nurturing and appropriate.

2.50 An emotionally abused child may be subject to constant criticism and being made a scapegoat, the continuous withholding of approval and affection, severe discipline or a total lack of appropriate boundaries and control. A child may be used to fulfil a parent's emotional needs.

2.51 The potential of emotional abuse should always be considered in referrals where instances of domestic violence have been reported.

Recognition of Emotional Abuse

2.52 Whilst emotional abuse can occur in the absence of other types of abuse, it is important to recognise that it does often co-exist with them, to a greater or lesser extent.

Child Behaviours associated with Emotional Abuse

2.53 Some of the symptoms and signs seen in children who are emotionally abused are presented below. It is the degree and persistence of such symptoms that should result in the consideration of emotional abuse as a possibility. Importantly, it should be remembered that whilst these symptoms may suggest emotional abuse they are not necessarily pathognomic of this since they often can be seen in other conditions.

2.54 Possible behaviours that may indicate emotional abuse include:

- serious emotional reactions, characterised by withdrawal, anxiety, social and home fears etc
- marked behavioural and conduct difficulties, e.g. opposition and aggression, stealing, running away, promiscuity, lying
- persistent relationship difficulties, e.g. extreme clinginess, intense separation reaction
- physical problems such as repeated illnesses, severe eating problems, severe toileting problems
- extremes of self-stimulatory behaviours, e.g. head banging, comfort seeking, masturbation etc.
- very low self-esteem, often unable to accept praise or to trust and lack of self-pride
- lack of any sense of pleasure in achievement, over-serious or apathetic

- over anxiety, e.g. constantly checking or over anxious to please
- developmental delay in young children, and failure to reach potential in learning.

Parental Behaviour Associated with Emotional Abuse

2.55 Behaviour shown by parents which, if persistent, may indicate emotionally abusive behaviour includes:

- extreme emotions and behaviours towards their child including criticism, negativity, rejecting attitudes, hostility etc
- fostering extreme dependency in the child
- harsh disciplining, inconsistent disciplining and the use of emotional sanctions such as withdrawal of love
- expectations and demands which are not appropriate for the developmental stage of the child, e.g. too high or too low
- exposure of the child to family violence and abuse
- inconsistent and unpredictable responses to the child
- contradictory, confusing or misleading messages in communicating with the child
- serious physical or psychiatric illness of a parent where the emotional needs of the child are not capable of being considered and/or appropriately met
- induction of the child into bizarre parental belief systems
- break-down in parental relationship with chronic, bitter conflict over contact or residence arrangements for the child
- major and repeated familial change, e.g. separations and reconstitution of families and/or changes of address
- making a child a scapegoat within the family.

Neglect

2.56 Neglect and failure to thrive / growth faltering for non-organic reasons requires medical diagnosis. Non-organic failure to thrive is where there is a poor growth for which no medical cause is found, especially when there is a dramatic improvement in growth on a nutritional diet away from the parent's care. Failure to thrive tends to be associated with young children but neglect can also cause

difficulties for older children.

2.57 There is a tendency to associate neglect with poverty and social disadvantage. Persistent neglect over long periods of time is likely to have causes other than poverty, however. There has to be a distinction made between financial poverty and emotional poverty.

2.58 There are a number of types of neglect that can occur separately or together, for example:

- medical neglect
- educational neglect
- stimulative neglect
- environmental neglect
- failure to provide adequate supervision and a safe environment.

Recognition of Neglect

2.59 Neglect is a chronic, persistent problem. The concerns about the parents not providing "good enough" care for their child will develop over time. It is the accumulation of such concerns which will trigger the need to invoke the Child Protection Process. In cases of neglect it is important that details about the standard of care of the child are recorded and there is regular inter-agency sharing of this information.

2.60 It is important to remember that the degree of neglect can fluctuate, sometimes rapidly, therefore ongoing inter-agency assessment and monitoring is essential.

2.61 The assessment of neglect should take account of the child's age and stage of development, whether the neglect is severe in nature and whether it is resulting in, or likely to result in, significant impairment to the child's health and development.

2.62 The following areas should be considered when assessing whether the quality of care a child receives constitutes neglect.

Child

2.63 Health presentation indicators include:

- non-organic failure to thrive (growth faltering)
- poor weight gain (improvement when away from the care of the parents
- poor height gain
- unmet medical needs
- untreated head lice/other infestations
- frequent attendance at 'accident and emergency' and/or frequent hospital admissions
- tired or depressed child, including a child who is anaemic or has rickets
- poor hygiene
- poor or inappropriate clothing for the time of year
- abnormal eating behaviour (bingeing or hoarding).

2.64 Emotional and behavioural development indicators include:

- developmental delay/special needs
- presents as being under-stimulated
- abnormal reaction to separation/ or attachment, disorder
- over-active and/or aggressive
- soiling and/or wetting
- repeated running away from home
- substance misuse
- offending behaviour, including stealing food
- teenage pregnancy.

2.65 Family and social relationship indicators include:

- high criticism/low warmth
- excluded by family

- sibling violence
- isolated child
- attachment disorders and /or seeking comfort from strangers
- left unattended/or to care for other children
- left to wander alone day or night
- constantly late to school/late being collected
- not wanting to go home from school or refusing to go to school
- poor attendance at school/nursery
- frequent name changes and/or change of address or parental figures within the home
- management of a child with a disability who is not attaining the level of functioning which is commensurate with the disability.

Consideration should be given as to whether a child and adolescent mental health assessment is required. Have all children in the family been seen and their views explored and documented?

Parents

2.66 Lack of emotional warmth indicators include:

- unrealistic expectations of child
- inability to consider or put child's needs first
- name calling/degrading remarks
- lack of appropriate affection for the child
- violence within the home from which the child is not shielded
- partner resenting non-biological child and hostile in attitude towards him
- failure to provide basic care for the child.

2.67 Lack of stability indicators include:

- frequent changes of partners
- poor family support/inappropriate support
- lack of consistent relationships

- frequent moves of home
- enforced unemployment
- drug, alcohol or substance dependency
- financial pressures/debt
- absence of local support networks, neighbours etc.

2.68 Issues relating to providing guidance and setting boundaries - indicators include:

- poor boundary setting
- inconsistent attitudes and reactions, especially to child's behaviour
- continuously failing appointments
- refusing offers of help and services
- failure to seek or use advice and/or help offered appropriately
- seeks to mislead professionals by providing inaccurate or confusing information
- failure to provide safe environment.

2.69 Social Presentation

- aggressive/threatening behaviour towards professionals and volunteers
- disguised compliance
- low self-esteem
- lack of self-care.

2.70 Health

- mental ill health
- substance misuse
- learning difficulties
- (post-natal) depression
- history of parental child abuse or poor parenting
- physical health.

Home and Environmental Conditions

2.71 The following home and environmental conditions should be considered:

- poor housing conditions
- overcrowding
- lack of water, heating, sanitation
- no access to washing machine
- piles of dirty washing
- little or no adequate clean bedding/furniture
- little or no food in cupboards
- human and/or animal excrement
- uncared for animals
- referrals to environmental health
- unsafe environment
- rural isolation.

2.72 Impediments to ongoing assessment and appropriate multi-disciplinary support

- failure to see the child
- no ease of access to whole house
- fear of violence and aggression
- failure to seek support and advice or consultation, as appropriate, from line manager
- failure to record concern and initial impact
- inability to retain objectivity
- unwitting collusion with family
- failure to see beyond conditions in the home
- child's view is lost
- geographical stereotyping
- minimising concern

- poor networking amongst professionals
- inability to see what is/is not acceptable;
- familiarity breeding contempt; and
- failure to make connections with information available from other services.

(Hammersmith & Fulham Inter-Agency Procedures 2002)

When staff become aware of any of the above features they should review the case with their line manager.

Children with Disability

2.73 In recognising child abuse, all professionals should be aware that children with a disability can be particularly vulnerable to abuse. They may need a high degree of physical care, they may have less access to protection and there may be a reluctance on the part of professionals to consider the possibility of abuse.

Recognition of Abuse of Children with Disability

2.74 Recognition of abuse can be difficult in that:

- symptoms and signs may be confused
- the child may not recognise the behaviour as abusive
- the child may have communication difficulties and be unable to disclose abuse
- there may be a dependency on several adults for intimate care
- there is a reluctance to accept that children with disabilities may be abused.

2.75 Children with disability will usually display the same symptoms and signs of abuse as other children. These may be incorrectly attributed, however, to the child's disability.

Risk Factors Associated with Child Abuse

2.76 A number of factors may increase the likelihood of abuse to a child. The following list is not exhaustive and does not preclude the possibility of abuse in families where none of these factors are evident.

Child

- poor bonding due to neo-natal problems
- attachment interfered with by multiple caring arrangements
- a 'difficult' child, a 'demanding' baby
- a child under five years is considered to be most vulnerable
- a child's name or sibling's names previously on the Child Protection Register
- a baby/child with feeding/sleeping difficulties
- birth defects/chronic illness/developmental delay.

Parents

- both young and immature (i.e. aged 20 years and under) at birth of the child
- parental history of deprivation and/or abuse
- slow jealousy and rivalry with the child
- expect the child to meet their needs
- unrealistic expectations/rigid ideas about child development
- history of mental illness in one or both parents
- history of domestic violence
- drug and alcohol misuse in one or both parents of the child
- frequent changes of carers
- history of aggressive behaviour by either parent
- unplanned pregnancy
- unrealistic expectations of themselves as parents.

Home and Environmental Conditions

- unemployment
- no income/poverty
- poor housing or overcrowded housing
- social isolation and no supportive family
- the family moves frequently
- debt
- large family.

APPENDIX 3

CONTACT ADDRESS - TELEPHONE NUMBERS

1. Eastern Health & Social Services Board

(a) Down Lisburn Health & Social Services Trust
Programme Manager - Family & Child Care
Health Centre
Linenhall Street
Lisburn BT28 1LU
Tel: 028 9266 5181

(b) North & West Belfast Health & Social Services Trust
Programme Manager - Family & Child Care
Glendinning House
6 Murray Street
Belfast BT1 6DP
Tel: 028 9032 7156

(c) South & East Belfast Health & Social Services Trust
Programme Manager - Family & Child Care
Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9056 5555

(d) Ulster Community & Hospital Trust
Programme Manager - Family & Child Care
Health & Care Centre
39 Regent Street
Newtownards BT23 4AD
Tel: 028 9181 6666

2. Northern Health & Social Services Board

(a) Causeway Health & Social Services Trust
Programme Manager - Family & Child Care
8E Coleraine Road
Ballymoney BT53 6BP
Tel: 028 2766 6600

(b) Home First Community Trust
Programme Manager - Family & Child Care
Pinewood Office
101 Fry's Road
Ballymena BT43 7EN
Tel: 028 2563 8662

3. Southern Health & Social Services Board

(a) Armagh & Dungannon Health & Social Services Trust
Programme Manager - Family & Child Care
Lisanally House
87 Lisanally Lane
Armagh BT61 7HF
Tel: 028 3752 2262

(b) Craigavon & Banbridge Health & Social Services Trust
Programme Manager - Family & Child Care
Child Care Office
2 Old Lurgan Road
Portadown
BT63 5SG
Tel: 028 3833 3747

(c) Newry & Mourne Health & Social Services Trust
Programme Manager - Family & Child Care
Oakdale House
Social Services Department
Drumalane Road
Newry
Co Down
BT35 8AP
Tel: 028 3082 5000

4. Western Health & Social Services Board

(a) Foyle Health & Social Services Trust
Programme Manager - Family & Child Care
Riverview House
Abercorn Road
Londonderry
BT48 6FB
Tel: 028 7126 6111

Duty and Initial Assessment Team
23A Bishop Street
Londonderry
BT48 6PR
Tel: 028 7127 3690

(b) Sperrin Lakeland Health & Social Services Trust
Community Services Manager (Child Protection & Family Support)
Community Services Department
2 Coleshill Road
Enniskillen
Co Fermanagh
BT74 7HG
Tel: 028 6634 4000

5. Out of Hours Emergency Services.

(a) Eastern Health & Social Services Board

Tel: 028 9056 5444

(b) Northern Health & Social Services Board

Tel: 028 9446 8833

(c) Southern Health & Social Services Board

- Craigavon Area Hospital
Tel: 028 3833 4444

- Daisy Hill Hospital
Tel: 028 3083 5000

- South Tyrone Hospital
Tel: 028 8772 2821

- St Luke's Hospital
Tel: 028 3752 2381

(d) Western Health & Social Services Board

- Altnagelvin Area Hospital
Tel: 028 7134 5171

- Erne Hospital
Tel: 028 6638 2000

- Tyrone County Hospital
Tel: 028 8283 3100

6. PSNI - CARE Units

Eastern Area
(a) Woodburn CARE Unit
139 Stewartstown Road
Belfast
BT11 9NB
Tel. 028 9025 9905

(b) Lisburn Road CARE Unit
Lisburn Road
Belfast
BT9 6GG
Tel. 028 9025 9856

(c) Willowfield CARE Unit
Willowfield Police Station
277 Woodstock Road
Belfast
BT6 8PR
Tel. 028 9025 9831

(d) Newtownards CARE Unit
36- 40 John Street
Newtownards
BT23 4LX
Tel. 028 9182 9007

(e) Newtownabbey CARE Unit
Newtownabbey Police Station
418 Shore Road
Newtownabbey
BT37 9RT
Tel. 028 9025 9305

Southern Area
(a) Mahon CARE Unit
Portadown
BT62 3SF
Tel. 028 3831 5274

(b) Ardmore CARE Unit
3 Belfast Road
Newry
BT34 1EF
Tel: 028 3025 9211

Northern Area
(a)Ballymena CARE Unit
26 Galgorm Road
Ballymena
BT43 5EX
Tel: 028 2566 7214

(b) Coleraine CARE Unit
17 Lodge Road
Coleraine
BT52 1LU
Tel: 028 7028 0904

Western Area
(a) Maydown CARE Unit
4 Maydown Road
Londonderry
BT47 6SJ
Tel: 028 7136 7337

(b)Enniskillen CARE Unit
Queen Street
Enniskillen
Tel: 028 6632 1562

7 SSAFA
Amendment to contact numbers in Appendix 1 of 'Co-operating to Safeguard Children'

Antrim & Ballymena	028 9445 5557
Ballykelly and Londonderry	028 7772 1365
Ballykinler, Armagh and Portadown	028 4461 0136
Holywood and Belfast	028 9042 0695
Lisburn	028 9226 6878
Omagh and Enniskillen	028 8225 8910

8 Education

(a) Belfast Education & Library Board
Chief Education Welfare Officer
40 Academy Street
Belfast
BT1 2NQ
Tel. 028 9056 4000

(b) Northern Eastern Education and Library Board
County Hall
182 Galgorm Road
Ballymena
BT42 1HN
Tel: 028 2566 2563

(c) South Eastern Education & Library Board
Chief Education Welfare Officer
Grahamsbridge Road
Dundonald
Belfast
BT16 1HS
Tel: 028 9056 6200

(d) Southern Education and Library Board
3 Charlemont Place
The Mall
Armagh
BT61 9AX
Tel: 028 3751 2200

(e) Western Education & Library Board
1 Hospital Road
Omagh
Co Tyrone
BT79 OAW
Tel: 028 8241 1411

(f) Council for Catholic Maintained Schools (Headquarters)
160 High Street
Holywood
Co Down
BT18 9HT
Tel: 028 9042 6972

(g) Council for Catholic Maintained Schools
Derry Diocesan Education Office
1a Millar Street
Derry
BT48 6SU
Tel: 028 7126 1931

(h) Council for Catholic Maintained Schools
Armagh Diocesan Education Office
1 Killyman Road
Dungannon
BT71 6DE
Tel: 028 8775 2116

(i) Council for Catholic Maintained Schools
Clogher Diocesan Education Office
8 Darling Street
Enniskillen
BT74 7EP
Tel: 028 6632 2709

(j) Council for Catholic Maintained Schools
Down and Connor Diocesan Education Office
193-195 Donegall Street
Belfast
BT1 2FL
Tel: 028 9032 7875

(k) Council for Catholic Maintained Schools
Dromore Diocesan Education Office
56 Armagh Road
Newry
BT35 6DA
Tel: 028 3026 2423

9 NSPCC

Divisional Office
Jennymount Business Park
North Derby Street
Belfast
BT15 3HN
Tel: 028 9035 1135
Helpline: 0808 800 5000

10 Health Service Executives in the Republic of Ireland

(a) Health Service Executive
Eastern Area
Chief Executive Officer
Dr Steevens Hospital
Steevens Lane
Dublin 8
Tel: 00 353 1 6352000

(b) Health Service Executive
South Eastern Area
Chief Executive Officer
Lacken
Dublin Road
Kilkenny
Tel: 00 353 56 7784100

(c) Health Service Executive
Southern Area
Chief Executive Officer
Wilton Road
Cork
Tel: 00 353 21 4545011

(d) Health Service Executive
Western Area
Merlin Park Regional Hospital
Galway
Tel: 00 353 91 751131

(e) Health Service Executive
North Eastern Area
Chief Executive Officer
Navan Road
Kells
County Meath
Tel: 00 353 46 9280500 or 00 353 46 9240341

(f) Health Service Executive
North Western Area
Chief Executive Officer
Manorhamilton
Co Leitrim
Tel: 00 353 71 9820440

(g) Health Service Executive
Mid Western Area
Chief Executive Officer
31/33 Catherine Street
Limerick
Tel: 00 353 61 483286

(h) Health Service Executive
Midland Area
Chief Executive Officer
Arden Road
Tullamore
County Offaly
Tel: 00 353 506 21868

11 Regional Health & Social Services Interpreting Service

Foyle Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH
Tel: 028 9056 3794

APPENDIX 4

CHILD PROTECTION REGISTRATION APPEALS PROCESS

4.1 The ACPC acknowledges that the process of a Child Protection Enquiry and subsequent attendance at a Child Protection Case Conference can leave some parents feeling dissatisfied about the process or the decision made. Each complaint needs to be taken seriously and the ACPC believes that there should be a clear procedure which enables complaints to be dealt with sensitively, thoroughly and without delay.

4.2 This appeals procedure should be used only for appeals which relate to decisions about placing a child's name on the Child Protection Register. Any complaint about individual agencies should be investigated through that agency's complaints procedure. It is separate from the 'Children Order Representation and Complaints Procedure'.

Persons Eligible to Appeal

4.3 Any person who has parental responsibility, or was invited as a parent to a child protection case conference for a child who has been subject to a child protection investigation and case conference.

4.4 Children, according to age and understanding, who have been subject to a child protection investigation and case conference may also appeal the decision.

Criteria for Appeal

4.5 The criteria for appeal are:

- ACPC procedures in respect of the case conference were not followed
- information presented at the case conference was inaccurate, incomplete or inadequately considered in the decision making process
- the threshold for registration/de-registration was not met
- the category for registration was not correct.

Process of Appeal

4.6 While an Appeal is being heard the decision of the case conference stands. The recommendations and Child Protection Plan will continue to be followed.

4.7 If a parent, or a child, wishes to appeal against a decision regarding registration or de-registration, he should inform the case co-ordinator within **14 days** of the case conference or, if he were not present at the case conference, of being advised of the decision.

4.8 The case co-ordinator will:

- discuss the parent's (and child's, if appropriate) concern with the Chairperson of the case conference
- arrange a meeting among the case co-ordinator, line manager, Chairperson and the parent within **7 days** of the parent's appeal of the decision.

4.9 The purpose of this meeting is to:

- allow the parent (and child, if appropriate) to voice his concerns and grounds on which he wishes to appeal the decision
- provide the opportunity to discuss the reasons for the decision
- resolve any issues
- advise about other complaints procedures.

4.10 The Chairperson of the case conference will decide if the criteria for an appeal is satisfied.

4.11 The parents (and child, if appropriate) should be informed in writing by the Chairperson about the decision and of how his appeal does/does not meet the criteria.

4.12 If new information is given by the parent the Chairperson should give consideration to reconvening the case conference. This should be done as soon as possible.

The Appeals Panel

4.13 If the criteria for an appeal is met, an appeals panel should meet within **14 days** of the decision to grant the appeal. The parent should be informed of this in writing by the Trust Director of Social Services.

4.14 The Appeals Panel will be made up of three people. The members of the panel should be:

i) Chair - a member of the Trust Child Protection Panel

ii) Two senior officers from agencies other than that of the Chair of the Appeals Panel; and

iii) One member must be from Social Services.

None should have been involved in the case conference that prompted the appeal.

4.15 The Panel will receive:

- a copy of correspondence about the appeal from and to the parents
- a copy of the relevant child protection case conference reports and minutes
- a copy of the record of the meeting among the parent, case co-ordinator, his line manager and case conference chairperson.

4.16 The Panel will:

- consider the written material
- meet with the parent (and child, if appropriate) if necessary
- interview the case conference chairperson
- interview any other case conference members, as necessary
- reach a recommendation about the Appeal and state the reasons for this
- write to the parent advising him of the Panel's recommendation and reasons for this.

Outcome of the Panel Decision

4.17 Appeal Upheld

- Where the Panel upholds the Appeal the Trust will reconvene the case conference within **15 working days**.
- The reconvened case conference should be chaired by a different senior officer from the Trust.
- The reconvened case conference must demonstrate that it has taken account of the recommendations from the Appeal Panel.
- The decision of the reconvened case conference will be final.
- If the parent is still dissatisfied he should be advised of his right to contact the Ombudsman or Commissioner for Children or seek legal advice.

4.18 Appeal Not Upheld

- The decision of the Panel is final.
- If the parent is still dissatisfied he should be advised of his right to contact the Ombudsman or Commissioner for Children or seek legal advice.

Individual Agency Responsibilities

4.19 It is expected that individual agencies will co-operate with the appeals process and provide information, if requested, to enable the process to reach a conclusion and make recommendations.

Recommendations to ACPC and TCPP

4.20 The Appeals Panel should identify any issues arising from the review of the case conference decision which relate to practice or procedures and advise the ACPC/TCPP accordingly.

AREA CHILD PROTECTION COMMITTEES

Eastern

Eastern Health & Social Services Board
Champion House
12-22 Linenhall Street
Belfast
BT2 8BS
Tel: 028 9032 1313
Website: http://www.ehssb.n-i.nhs.uk

Northern

Northern Health & Social Services Board
County Hall
182 Galgorm Road
Ballymena
BT42 1QB
Tel: 028 2565 3333
Website: http://www.nhssb.n-i.nhs.uk

Western

Western Health & Social Services Board
15 Gransha Park
Clooney Road
Londonderry
BT47 1TG
Tel: 028 7186 0086
Website: http://www.whssb.org

Southern

Southern Health & Social Services Board
Tower Hill
Armagh
BT61 9DR
Tel: 028 3741 0041
Website: http://www.shssb.org

NAMES, ADDRESSES AND TELEPHONE NUMBERS

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