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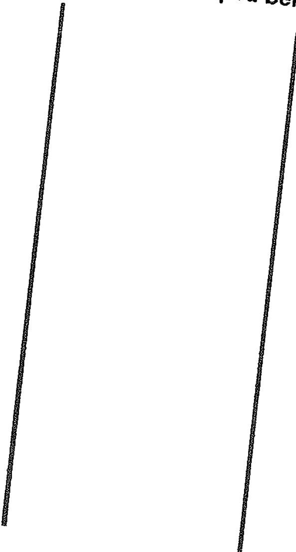
GUIDANCE ON ABUSE
OF VULNERABLE ADULTS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GUIDANCE ON ABUSE OF VULNERABLE ADULTS

INTRODUCTION

1.1 The purpose of this guidance is to ensure that all purchasers and providers of services to vulnerable adults have in place policies and practical arrangements for the prevention, detection and investigation of abuse.

1.2 Everyone has a right to freedom from abuse. Vulnerable people cannot always protect themselves from abuse. The Department is of the opinion that it is only when clear policy guidance is issued at area level and statements and codes of practice are drawn up at a local level - indeed within individual facilities including non-statutory facilities - that the complex factors interacting in abuse of vulnerable adults can be dealt with adequately. This guidance sets out the issues involved.

DEFINITION OF ABUSE

2.1 How abuse is defined will determine the circumstances in which intervention takes place. The following definition is suggested:-

The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship.

2.2 Abuse can occur within any client group; it can take many forms; and it can occur in any setting. This guidance is applicable to abuse of all vulnerable adults, elderly people, people with a physical or learning disability and people suffering from mental illness; and covers all types of abuse, including neglect.

2.3 Appendix 1 identifies different forms of abuse and their associated indicators.

PRINCIPLES

3.1 There are a number of principles which should underpin policy and guidance on abuse. These are:-

- vulnerable adults have a right regardless of their disability, age, gender, and cultural or ethnic background, to expect:-
  - to be accorded the same respect as any other adult;
  - information on, and practical help in, keeping themselves safe and protecting themselves from abuse;
  - guidance and assistance when making a complaint or seeking help as a consequence of abuse;
  - an urgent investigation of alleged, suspected or confirmed abuse;
  - to be supported in making their own decisions about how they wish to proceed in the event of abuse, and to whom they wish to confide; and to know that their wishes will only be overridden if it is considered necessary for their safety or the safety of others;
  - to be supported in bringing a formal complaint under a Board's or HSS Trust's Complaints Procedure if they are not satisfied with the outcome of any investigation. Complaints procedures should take account of the needs of vulnerable adults;
  - to be supported in reporting the circumstances of any abuse to independent bodies such as the police, Registration and Inspection Units, and the Mental Health Commission;
  - to receive, where they have been abused, support, education, counselling, therapy, and treatment;
  - redress, where possible, regardless of whether their case was determined by a court or other means;
- parents, informal carers and advocates have a right to expect the vulnerable adult's rights to be respected and to act on his or her behalf where they are not;
- where it is necessary to protect the victim from further abuse, alternatives which do not involve removing him or her from the place where the abuse has taken place and which minimise disruption should be explored;
- there should be good communication between those working with the victim, carers and the abuser;

- where a member of staff has good reason to believe that any person with whom he or she is in contact presents a risk to a vulnerable adult he or she should bring this to the attention of the appropriate authority.

3.2 Where there may be a conflict in applying these principles, protection of the vulnerable adult from further abuse should be the paramount consideration.

RECOGNISING AND PREVENTING ABUSE

4.1 Everyone having contact with vulnerable adults should be aware of what abuse is and the indicators of abuse. Providers of services, whether in the statutory, voluntary or private sectors should ensure that staff receive training in abuse awareness. Informal carers should be given appropriate information on abuse.

4.2 Abuse may be prevented and the opportunity for its occurrence reduced through the following measures:

- clear policy and practices on abuse issues;

- sound selection and recruitment procedures. The Department's Pre-Employment Consultancy Service (PECS) is available to approved organisations with posts involving substantial access to people with a learning disability. The Registered Homes (Northern Ireland) Order 1994 provides that registration will be refused or withdrawn where anyone concerned in carrying on or intending to carry on a home, or employed or to be employed in a home is not a fit person;

- induction and ongoing training;

- good supervision and management practices;

- minimising the opportunity for routine, unsupervised access to vulnerable adults;

- increasing family and informal carer awareness of abuse through appropriate training;

- access to an advocate, especially for people with communication difficulties;

- education about personal relationships. Advice on personal and sexual development of people with a learning disability is set out in the Department's circular letter of 17 May 1990.

REPORTING ABUSE

5.1 Local codes of practice should set out clearly the reporting procedures to be followed where abuse is suspected. Procedures may vary according to the circumstances of the case, for example according to the setting in which the abuse has occurred, the form of abuse, or to whether the abuser is a member of staff, a family member or other informal carer, a visitor or any other person.

5.2 Particular attention needs to be given to abuse by staff and/or management in hospitals, nursing homes, residential care homes, day centres or other institutional settings. In this type of situation it may not be desirable or appropriate for the victim or others to approach the management and very often the victim is too afraid to speak out.

5.3 Staff may also be reluctant to report suspicions or evidence in certain circumstances. Everyone working with vulnerable adults should understand that they have a responsibility for their protection and to take the appropriate action. **Everyone has a duty to report suspected, alleged or confirmed incidences of abuse.** When a member of staff suspects or has evidence that abuse is taking place this should be reported **immediately**.

INVESTIGATING ABUSE

6.1 Local codes of practice should indicate the circumstances when an allegation of abuse **must** have an initial investigation **within 24 hours**. In all other circumstances allegations of abuse should be subject to an initial investigation within 72 hours. Further action will be determined by the outcome of the initial investigation.

6.2 The investigation of abuse should be conducted in a sensitive, but effective, manner so as to minimise any further distress to the victim. This will be particularly important in cases which require police involvement or a medical examination.

6.3 Investigation of abuse should normally proceed with the consent of the victim (where he or she is able to give such consent). Consent is the voluntary and continuing agreement of the victim to the action to be taken in pursuit of an investigation, based on an adequate knowledge of the nature, purpose and likely effect of that action. The victim may be reluctant to cooperate with any investigation or to consent to any disclosure to the police eg where the abuser is a family member or other close friend. This should not preclude pursuit of the investigation or the involvement of the police. Cases of physical or sexual abuse will normally require a medical examination with the consent of the victim.

6.4 The objectives of an investigation into abuse should include:

- establishment of the facts;

- an initial assessment;

- protection of the victim: where the abuser is himself or herself a vulnerable adult he or she will also need protection.

6.5 The investigation of abuse is often a complex process as abuse is rarely witnessed and many forms of abuse eg sexual, psychological or financial abuse, are more difficult to detect than others. It is essential that all professionals having contact with a vulnerable adult have a mechanism for sharing concerns and information. Codes of practice should specify reporting arrangements where abuse is suspected and mechanisms for sharing concerns and information by everyone in contact with the vulnerable adult.

FOLLOW UP ACTION

7.1 Where action has been taken to protect a victim of abuse or suspected abuse the outcome should be monitored to determine the effectiveness of that action. Arrangements for monitoring should be set out in codes of practice. Where the victim is considered to be still at risk the case should be reviewed **within 24 hours** and further action taken as considered necessary to safeguard the victim.

TRAINING ISSUES

8.1 Training is the cornerstone of any strategy for the protection of vulnerable adults. Policy guidance, statements and codes of practice should:-

- identify the lead role in ensuring that all who work with vulnerable adults, regardless of whether they are employed or volunteers and of where and by whomsoever they are employed, receive appropriate training; and

- determine what training is appropriate.

8.2 Training programmes should include:-

- recognition of signs of potential abuse (see Appendix 1) and what immediate action to take;

- investigation of abuse;

- provision and monitoring of protection from abuse;

- multi-disciplinary and inter-agency cooperation.

ACTION

9.1 Boards should, if they have not already done so, establish clear policies for dealing with abuse throughout their areas. They should ensure that providers with whom they contract for services have in place a statement and codes of practice on abuse which complies with Board policies.

9.2 The Department appreciates that this is a difficult and complex area. It is also aware that there will be much in common in the guidance appropriate in each Board. Boards may therefore consider that production of policy guidance on abuse is an area in which they might cooperate (with advice from provider units) with a view to producing guidance to which they could subscribe absolutely or with a minimum of adaptation. Work already undertaken by a Board or Trust in the area of abuse may assist in this task. In preparing their guidance, Boards may find the publications listed in Appendix 2 helpful.

9.3 Providers are asked to draw up a statement on abuse in accordance with Board policy, and a code or codes of practice on the prevention, detection, reporting and investigation (including involvement of the police) of abuse, and follow up action. They should ensure that their statements and codes of practice are brought to the attention of all staff. In preparing their codes of practice providers may find the publications listed in Appendix 2 helpful.

9.4 A clause on abuse should be included in service contracts and agreements. Fulfillment of this clause should feature in contract monitoring procedures.

9.5 Periodic reviews of policy guidance, statements and codes of practice should be undertaken to ensure that these are updated in the light of national, regional or local developments.

9.6 The Management Executive will monitor the action taken by Boards and Trusts on the requirements of this circular. General Managers and Chief Executives are asked to advise the Management Executive by 30 June 1996 of the action they have taken in pursuance of this circular.

APPENDIX 1

FORMS OF ABUSE AND ASSOCIATED INDICATORS

The indicators listed below under each form of abuse are not exhaustive nor should they be taken as definitive proof that abuse has taken place. Many could equally indicate an alternative form of abuse. There may be other indicators which should not be ignored.

The victim may be subject to a number of forms of abuse.

Adults with particular disabilities can be more susceptible to certain types of abuse than others. For example adults with a learning disability may be unwitting victims of sexual or financial abuse. Immobile adults are less able to avoid certain forms of physical abuse.

Often the victim will be too intimidated, or afraid to complain that he or she is being abused. Those with communication difficulties may be unable make their to complaints understood.

Any suggestion that all is not well should be seen as an indicator of possible abuse of one form or another.

Physical Abuse

The consequences of physical abuse can range from mild discomfort to serious injury and even death through:

- physical assault
- deprivation of nutrition
- force feeding
- administration of inappropriate medication
- withholding prescribed medication
- over-sedation
- inappropriate restraint

Indicators

Multiple bruising
Black eyes
Bite marks
Injuries not consistent with explanation given
Explanations of injuries inconsistent with medical findings
Repeated attendance at GP surgeries or Casualty Departments for injuries which are not adequately explained
Signs of malnutrition
Signs of force feeding eg bruising around mouth
Poor safety standards
Inadequate heating
Inappropriate drug therapy
Non-treatment of illness or injury
Substance mis-use
Withdrawal of supplied aids eg hearing aid, glasses etc
Change in personality/behaviour

Sexual Abuse

This is involvement in sexual activities to which consent has not been given or cannot be given, or which violate the social/sexual taboos of family roles, or which are against the law. Consent is the voluntary acquiesence to the sexual activity based on an adequate knowledge of its nature, purpose, and consequences. Staff should have a clear understanding of the complexities involved in ascertaining someone's ability to give consent.

Sexual abuse can take many forms:

- lewd or licentious behaviour
- pornographic photography
- indecent exposure
- harassment, serious teasing or innuendo
- touching especially of breasts, genitals, anus or mouth
- penetration or attempted penetration
- masturbation of either or both persons

Indicators

Signs of avoidance or fear
Pain, bruising or bleeding in the genital, vaginal or anal areas
Blood stained underclothing
Difficulty in walking/sitting
Frequency of urine
Other discharges
Faecal smearing
Venereal disease
Oral bruising or ulceration
Inappropriate relationships
Overt sexual behaviour/language
"Love" bites
Change in personality/behaviour

Psychological/Emotional Abuse

Psychological and emotional abuse can be particularly difficult to detect. It can be inflicted by:-

- intimidation, humiliation, harassment, threatening or insulting behaviour, causing fear, rejection, verbal abuse
- lack of appropriate stimulation
- denial of basic rights including choice, opinion or privacy
- overprotection - not allowed to live a normal life
- involuntary isolation

Indicators

Withdrawn, agitated, anxious or fearful behaviour
Isolation
Inappropriate or improper dress
Unkept or unwashed
Overt subservience, anxious to please
Denied or unreasonably restricted access
Change in personality/behaviour

Financial Abuse

Financial abuse is interference with or deprivation of finances by any of the following means:-

- theft
- withholding money or benefits money can buy
- forced signing over of social security benefits, pensions or other property
- withdrawal of money from bank or other accounts
- deprivation of appropriate care in order to retain benefits of both cash and kind
- refusal of care because of financial cost
- blocking access to material goods
- mis-use of property or finances
- inappropriate charging for services
- fraud

Indicators

Unpaid bills
Lack of appropriate clothing
Lack of food
Unkempt appearance
Unexplained withdrawal of money from accounts
Disparity between assets and satisfactory living conditions
Inappropriate interest by family members or others in assets

Neglect

Neglect is the wilful failure to provide appropriate care and may include:

- failure to provide care and attention
- failure to access available support
- omission in exercise of duty to care

- provision of inappropriate care and attention
- deprivation of equipment

Indicators

Lack of appropriate clothing
Lack of food
Unkempt appearance
Signs of malnutrition
Inadequate heating
Lack of essential equipment

APPENDIX 2

REFERENCE MATERIAL

NO LONGER AFRAID The Safeguard of older people in domestic settings (Social Services Inspectorate, Department of Health, London 1993).

IT COULD NEVER HAPPEN HERE! The prevention and treatment of sexual abuse of adults with learning disabilities in residential settings (The Association for Residential Care (ARC) and National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (NAPSAC) 1993).

CONSENTING ADULTS? Sexual abuse and adults with learning disabilities - a framework for practice guidance (ENABLE, Glasgow 1993).

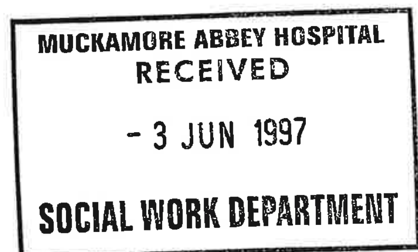
There may also be a range of relevant material on abuse published by Local Authorities in Great Britain and by Boards and Trusts in Northern Ireland.

PAPER NO EB/47/97

EASTERN HEALTH AND SOCIAL SERVICES BOARD

PROTECTION OF VULNERABLE ADULTS

POLICY AND PROCEDURES



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INTRODUCTION

Health and Personal Social Services Trusts share with other agencies the responsibility of providing services to people who are vulnerable through illness, frailty or disability. Most vulnerable people are supported by committed families and other carers on a long-term basis and the question of abuse will not arise for the vast majority of these people. Much of the abuse that is reported occurs outside of a caring family environment. However, it has also to be acknowledged that the stress of caring or the complex nature of relationships between the vulnerable person and their carers can lead to abusive behaviour. This can occur within a family but also within a service or facility provided by statutory or independent providers.

Eastern Health and Social Services Board's policy for the protection of vulnerable adults has been produced in response to the Department of Health and Social Services "Guidance on Abuse of Vulnerable Adults" [(1)]. The purpose of this policy is to make clear the Board's requirement that service providers respond to situations where some form of abuse has been identified or is suspected. The policy is intended to promote good practice in responding to these situations and to provide guidance for providers in developing their practices and procedures for dealing with abuse. More specifically it will aim to prevent abuse by:

- promoting a multi-disciplinary approach to vulnerable adult protection;
- providing a basis for identifying those in need of protection;
- outlining the process of intervention;
- raising awareness of vulnerable adult abuse among professionals and the public.

POLICY

The Eastern Health and Social Services Board affirms that all vulnerable adults have the right to freedom from abuse. It expects that all agencies providing health and social services to its population will take all the necessary and appropriate measures to:

ensure that abuse does not occur within any of the services for which they are responsible;

[1)]Guidance on Abuse of Vulnerable Adults - March 1996. HPSS Management Executive Child and Community Care Directorate

- respond to all cases of suspected or alleged abuse of vulnerable adults with whom they come into contact whether the source is a member of staff, a relative or any other person (this could take the form of advice, support or investigation);
- protect and support individuals where abuse is established;
- resolve the situation in which the abuse has occurred, including working with abusers;
- involve all appropriate agencies, such as the RUC and Registration and Inspection unit when necessary.

The Board requires that all cases of alleged or suspected abuse will be handled promptly and sensitively. There should be due regard for the needs and wishes of the vulnerable person, where this is consistent with the needs and rights of others who may be at risk, and the legal obligations of agencies. The primary concern should be to protect the individual and, where possible, resolve the abuse expeditiously. It is anticipated that most situations where abuse is reported or suspected will be resolved by the professional worker, usually in contact with the vulnerable person.

The procedures for dealing with abuse (see page 9-21) make provision for the initial response to be made by the person in this role. They are also designed so that, where appropriate particular cases can be resolved without implementing the procedures in full.

SCOPE OF POLICY

This policy is applicable to abuse of all vulnerable adults. This includes elderly people, people with a learning, physical or sensory disability and people suffering from mental illness or dementia. It covers all types of abuse, including neglect and recognises that vulnerable people cannot always protect themselves from abuse.

The policy will apply to all health and personal social services agencies providing services to vulnerable adults whether they are statutory, voluntary or private providers. This policy replaces the Board's Elder Protection Policy.

The requirements of the policy and procedures will be reflected in contracts between purchasers and providers of services. The policy will form the principles of good practice in working with vulnerable adults.

RIGHTS OF VULNERABLE ADULTS

It is recommended that all work with vulnerable adults should be underpinned with the set of values which provide and support the rights of all individuals. These are:

Privacy	-	the right of an individual to be left alone or undisturbed and free from intrusion or public attention into their affairs;
Dignity	-	recognition of the intrinsic value of people regardless of their circumstances by acknowledging their uniqueness and treating them with respect;
Independence	-	opportunities to act and think without reference to another person, including a willingness to incur a degree of calculated risk;
Choice	-	opportunity to select independently from a range of options;
Citizenship	-	the maintenance of all rights and duties associated with citizenship;
Fulfilment	-	the opportunity to pursue the realisation of personal aspirations and the recognition of his/her abilities in all aspects of daily living.

The Board believes that the application of these values to situations of potential abuse means that adults who are vulnerable have the right:

- to live safely without fear of violence or abuse in any form;
- to have their money, goods and possessions treated with respect and to receive the same protection for themselves and their property under the law as any other citizen;
- to information on, and practical help in protecting themselves from abuse;
- to be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-ridden if it is considered necessary for the safety of others, or for their own safety in circumstances where they are not competent to decide this for themselves;

- to be given information about and be supported in bringing a complaint under any existing complaints procedure; (including complaints about the investigative process or outcomes);
- to be supported in reporting the circumstances of any abuse to independent bodies, such as the Health and Social Services Council, the Mental Health Commission, the Police, the Registration and Inspection Unit and advocacy schemes;
- to have alleged, suspected or confirmed cases of abuse investigated urgently;
- to receive appropriate support, education, counselling, therapy and treatment following abuse;
- to seek redress through appropriate agencies;
- to have their nearest relative, informal carer or advocates act on their behalf, where necessary.

DEFINITION AND MAIN FORMS OF ABUSE (See Appendix 1)

The Department of Health and Social Services in its guidance on abuse of vulnerable adults defines abuse as:-

"The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependent, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship." (Page 1, DHSS 1996) [1]

The main forms which abuse can take are:-

PHYSICAL ABUSE

Physical abuse is violence, resulting in bodily harm or mental distress. It includes assault, unjustified denial of rights and restrictions of the freedom of movement. However, in some instances it can be difficult to confirm as injuries can be sustained through frailty and other medical conditions. Medical opinion may be required as not all physical signs of bruising are due to Abuse.

SEXUAL ABUSE

This is the involvement of a vulnerable person in sexual activities to which they have not consented or are unable to give consent, or that breeches the law as it effects all adults.

FINANCIAL ABUSE

This involves a theft or obtaining of money, objects or property belonging to a person, who is vulnerable. It is accomplished by withholding benefit, the use of threat of force or through misrepresentation.

[1] *Guidance on Abuse of Vulnerable Adults - March 1996. HPSS Management Executive Child and Community Care Directorate*

PSYCHOLOGICAL AND EMOTIONAL ABUSE

This is the threat of violence or isolation, including name calling and other forms of assault. It also includes denial of basic rights, inclusive of choice, opinion or privacy.

MISUSE OF MEDICATION

The administration or with-holding of mediation for other than legitimate therapeutic purposes.

INSTITUTIONAL ABUSE

Institutional abuse occurs when inappropriate practices or systems are employed within facilities which deny residents rights of choice, privacy and independence, and when staff become desensitised and accept as reasonable, practices which their personal principles would lead them to question outside the establishment.

NEGLIGENCE

Negligence is the breach of duty or carelessness that results in injury to the Vulnerable person. This may include the with-holding of help in performing activities of daily living. Sometimes this form of abuse may be passive, eg., a failure to understand or respond to the implications of a medical situation. It needs to be recognised however that sometimes this lack of understanding may result from inadequate counselling, supervision and training or information.

More detailed information about abuse and associated indicators is reproduced from the Department of Health and Social Services' Guidance on Abuse of Vulnerable Adults in Appendix 1.

CONSENT

In deciding what action should be taken about alleged or suspected abuse, the issue of consent requires careful consideration. Two questions need to be addressed:

1. Did the vulnerable adult give meaningful consent to the act, relationship or situation which constitutes the abuse?

2. Do they now give meaningful consent to any preventive action, investigation or report to the police (where a crime is suspected) that may be considered necessary?

To be meaningful, consent must be freely given on the basis of knowledge and understanding. Meaningful consent cannot be determined easily and no procedure can be written that will clearly identify when it has or has not been given. Careful consideration will need to be given to a number of questions including:

- the mental capacity of the vulnerable adult;
- whether the severity or nature of their condition significantly undermines their understanding and renders them incapable of giving consent;
- whether any incapacity is temporary or permenant;
- whether unreasonable or undue pressure was applied to obtain consent;
- the legislation applicable to the giving or with holding of consent;
- whether the law permits the vulnerable adult to give consent to a particular act or relationship.

It should not be presumed that a vulnerable adult is incapable of giving consent on the grounds of a mental illness or learning disability alone. In most cases it is expected that it will be determined that the vulnerable adult is able to give meaningful consent and their wishes should be respected except where this creates a conflict with a duty to protect others or the law (see below).

Before reaching any decision about the ability of the vulnerable adult to give meaningful consent, it is essential that staff consult with their managerial and professional lines and that legal advice is obtained.

DISPENSING WITH CONSENT

There will be some circumstances in which it will be necessary to override the wishes of the vulnerable adult even though they are deemed to be capable of giving meaningful consent:

- where there is an overriding public interest, for example to prevent serious harm or injury to others;
- to prosecute a serious criminal offence. It should be noted that there is a common law duty for all citizens to report suspected crime to the police.

As when considering the vulnerable adult's ability to give meaningful consent, there should be full discussion and reference to legal advice before any decision is made.

In all cases where the wishes of the individual are overridden, this should be fully explained to the individual and their carer or advocate when appropriate. In these cases the wishes and best interests of the individual should still receive full consideration in any decisions that are subsequently made.

CONFIDENTIALITY

"All HPSS bodies and those carrying out functions on behalf of the HPSS have a common law duty of confidence to patients and clients and a duty to support professional ethical standards of confidentiality" (Page 7 DHSS 1996).* Information given by an individual about abuse should only be disclosed to those who need it in order to plan or manage any care or treatment that the person may require. Such information should not be disclosed to any one else except where disclosure is required by law or by order of the court. It may also be necessary to disclose confidential information in order to protect others or to prosecute serious crime as discussed in the section on consent.

**The protection and Use of Patient and Client Information (DHSS 1996)*

PROCEDURES FRAMEWORK

INTRODUCTION

The procedures which follow provide a framework within which Trusts may develop their own procedures. The framework is designed to take account of:

- the range of settings in which abuse may arise;
- the different forms that abuse can take;
- the varying levels of risk and danger to the individual concerned; and
- the varying degrees of urgency which may be required in responding to referrals.

The primary purpose of these procedures is to ensure that vulnerable adults are protected from abuse and the underlying causes of abuse are addressed. They should be carried out in a way that most effectively resolves the problem raised with the minimum of disruption and delay for those involved, consistent with legal and policy requirements.

The procedures do not operate independently of others such as complaints and disciplinary procedures. These may need to take precedence over the vulnerable adult protection investigation procedures in particular cases. Where there is evidence that a criminal act has been or is about to be committed, it will be necessary to involve the police and to consult them with regard to the investigation (see Notification to Police, page 20. Any action necessary for the protection of the abused person should be taken as a matter of urgency in liaison with the police.

In applying the abuse procedures, the underlying principle should be that only action that is necessary to protect the individual (and any others who may be affected) and to resolve the situation should be taken. Ideally, abuse referrals will be resolved without recourse to the full procedures through timely and professional intervention by those workers who are close to the individual concerned. The procedures are designed to allow for matters to be resolved in the most appropriate way at any stage of the process of inquiry or investigation. It is the Board's expectation that Trusts will apply this principle to their procedures.

There are four main settings in which abuse may be identified:

- Domiciliary Settings (the individual's home)
- Day Services

- Residential and Nursing Homes
- Hospitals (including day hospitals, out-patient clinics etc).

The general approach to investigating abuse will be the same irrespective of setting. This means that within each setting the response should be appropriate to the circumstances of each case and the inquiry or investigation will follow the same broad process, with similar opportunities to resolve matters at any stage, if appropriate. However, if there is a question of staff involvement in the alleged or suspected abuse in any of these settings, the disciplinary procedures will be applied and, if any other action is considered necessary to protect the individual or to resolve the situation, full account will have to be taken of the impact on the disciplinary inquiry. Similarly, if the complaints procedure is invoked, this will become the primary means through which an inquiry is conducted. It will be necessary however, to consider any immediate protection .

The main difference that should be noted in the way the procedures operate in any of the four main settings is in the roles of the professional staff who are identified as the Designated Officer or the Investigating Professional. It will be the responsibility of each Trust to decide how these roles should be assigned.

It is possible that abuse that is identified in one setting may have its origins in another setting. For example, the first indication of someone being physically abused in their own home may be picked up at an out-patient clinic or on admission to hospital for an unrelated condition. While initial inquiries to establish the source of abuse may be carried out in the setting where it first comes to light, responsibility for any formal investigation will be decided on the basis of who is best placed to carry out an investigation. However there will be a need for very close liaison between professionals in each setting to ensure effective co-ordination of any investigation or other action. Where separate Community and Hospital Trusts are involved, formal liaison channels should be established.

ROLES

The terms of Designated Officer and Investigating Officer are used to describe specific functions within the procedures, as shown below. It is not intended that these roles should be the responsibility of any single professional group. The main consideration in assigning the roles should be the competence of the individual to carry out the associated responsibilities. It is not assumed that either of these roles will be a new post.

Designated Officer

This role requires an experienced practitioner who has expertise in the area of abuse and in the process of investigation.

As outlined in the procedures, there will be opportunities to make decisions not to proceed further with the procedures.

1. Primary in the skills required will be that of organisation. The Designated Officer will be required to co-ordinate the investigation liaise with colleagues and other organisations. They will be required to keep detailed notes of information received, decisions made and the actions taken.

2. The Designated Officer will have to have experience of assessment and planning; and have a wide knowledge of the services available locally, including those provided by other professional groups.

3. This work will require that there is an assessment of the risks involved and an ability to accept them. This may require that the Designated Officer represents the Trust in any enquiries which result from the investigation.

4. Given that Designated Officers will provide line management support to the Investigating Officer, they will need to have the skills and knowledge necessary to provide supervision.

5. Finally, they will require the skills necessary to chair case conferences where conflict may be encountered.

6. They will be aware of the legislation which applies and will keep themselves up to date on any changes.

The Designated Officer is the co-ordinating professional responsible for the continuation of the investigation. They will have sufficient authority to initiate and chair a case conference and to liaise with professional colleagues. The Designated Officer will require to be experienced within their own field ie. Elderly, Physical Disability, Learning Disability with a minimum grade of Team Leader or their equivalent. The expectation would be that it is part of the duties already undertaken by the person or persons nominated by the Trusts.

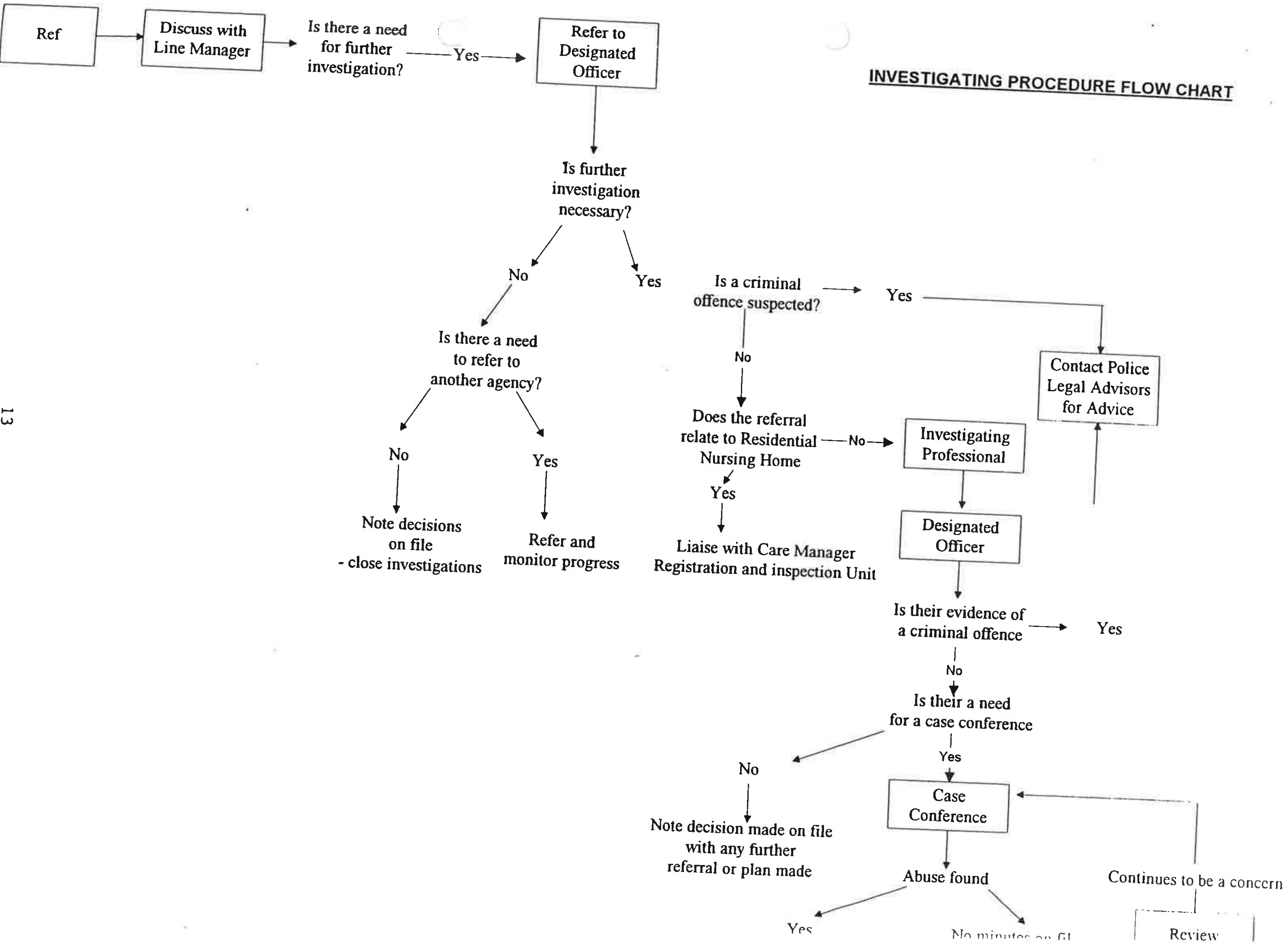
Investigating Professional

This role will require an experienced professional. They will:

- have skills in assessing, risk and the needs of clients/carers;
- plan and look at alternatives available;
- provide counselling and support;
- confront perpetrators where appropriate;
- work with perpetrators who may also be Vulnerable Adults;
- have Experience of Multi-Disciplinary working;
- be aware of the legislation which applies and will keep themselves up to date on any changes.

They will be responsible for direct contact with clients, carers or relatives involved in the case. Their role is to establish the facts, look at alternatives available and provide counselling and support. When carrying out these duties they will be line managed by the Designated Officer.

INVESTIGATING PROCEDURE FLOW CHART



PROCEDURE GUIDELINES

1. Referral may come from any person who has knowledge or a reasonable suspicion that a vulnerable adult is, or is at risk of, being abused. Everyone working with Vulnerable Adults has a duty to report suspected, alleged or confirmed incidences of abuse.

2. Any member of staff from the Trust, voluntary or private agency involved with vulnerable people, who receives information about alleged abuse from an identified member of the general public, or anonymously, should obtain as much information as possible from the referrer. They should treat the information in the same manner as if he/she had originated it. Where there has not been previous contact with the vulnerable person, the normal referral details, name, address, age, GP, etc. would also be required.

Any member of staff of the Trust should, on suspicion of abuse or on receipt of such information, immediately inform his/her line manager. Where the abuse relates to the line manager they should inform a more senior manager, in accordance with individual professional/agency guidelines. All staff working with vulnerable adults should be given guidance by their employer, on referring suspected abuse. This guidance should take account of whether the abuser is a member of staff, a family member or informal carer, visitor or any other person. It should also require staff to seek as much information and advice is as necessary to make an informed judgement about the need to refer for investigation, eg. in the case of bruising, medical opinion should be sought, as not all physical signs of bruising are due to abuse.

4. The judgements made at this stage can be the subject of consultation with fellow professionals, or the Designated Officer. However, any decisions made should be within the professional competence of those involved. Taking the example quoted of bruising, the decision not to proceed would be on medical advice and guidance, probably from a GP. This advice should be clearly noted on the client file. In any record keeping it should be borne in mind that they may be used as evidence.

5. In all instances where an investigation is not pursued, the reasons for this decision, the personnel involved and any contrary advice should be clearly noted. The file note should be signed by the professional involved and countersigned by the line manager. Where there is a difference of opinion as to whether the investigation should be pursued, the line manager should consult with the appropriate Designated Officer.

6. All referrals for further investigation should be made to the appropriate Designated Officer. This contact may be made by telephone in the first

instance If the referral is from a professional or agency involved with vulnerable adults it should be confirmed within 2 working days. In the absence of the Designated Officer arrangements should be made for the receipt of referrals. Outside normal office hours, referrals should be made to the Social Work staff undertaking after-hours duty. These staff can be reached through the Contractor's bureau (01232-668246).

7. The Designated Officer should record telephone referrals. If the referral is from a member of the public, he/she should ascertain whether the person who originated the referral is willing to be identified as the referrer. In addition the Designated Officer should, where appropriate, inform the Police and confirm this in writing within 2 working days. (See Notification to Police page 20). They should also establish whether the vulnerable adult is aware of the referral.

8. When deciding the level of urgency of any referral, the degree of apparent risk, rather than the type of abuse, will be the deciding factor. Some cases of abuse will need a rapid response and service provision must allow for this. Life threatening situations, such as severe physical abuse, require an immediate response. In all other circumstances allegations of abuse should be the subject of an initial investigation within 72 hours.

9. Having gathered what information is available and consulted if appropriate with the Police, Legal Advisors or senior colleagues, the Designated Officer can make one of three decisions.

   i) that no further action is required under the procedures for example where the referrer can resolve the presenting problem

   ii) that other options are available, which may provide a solution such as referral to other professionals.

   iii) that further investigation is required for example where there is no obvious solution.

   This decision should be clearly recorded with notes on the reason for making the decision.

10. The Investigating Professional will interview the vulnerable adult and any carer/relative separately. The process of investigation may take several interviews. The needs of the vulnerable adult, carer or carers and, where appropriate, the alleged abuser should be considered. Investigations need to be handled with the utmost sensitivity, recognising that both parties may have a continuing relationship into the future. The vulnerable person may wish to have someone else present during the interview - a carer, friend, independent advocate or

another member of staff. This should be facilitated where possible. There may also be the need to have an interpreter where communication difficulties arise.

11. Where physical, sexual or financial abuse has taken place, the individual should be informed of his/her rights to protection under law, for example to inform the Police of theft, fraud or assault. This would be particularly the case where an individual does not suffer from any form of mental disorder. If dementia, learning disability, brain injury or mental illness is a factor, a professional judgement will have to be made as to how these matters should be dealt with. The advice of the Psychiatrist/ Psychogeriatrician should be sought.(see consent page 7)

12. Where abuse has been suspected the Investigating Professional must take immediate preventive action, while recognising the vulnerable adult's right to refuse protection. In any case of physical or other forms of abuse, a complete medical assessment should be offered. Where there are other forms of abuse, the need for a medical assessment should be considered. While a competent vulnerable person may refuse protection, it is the duty of the Investigating Professional to actively encourage the person to participate in an action plan to prevent recurrence of the abuse.

13. Immediate action should include the consideration of the provision of domiciliary supports to reduce the immediate risks, alternative accommodation for the vulnerable adult or, where appropriate, the abuser. In these circumstances the existing procedures for emergency admission to a hostel, residential or nursing home should be followed and a full assessment of need undertaken, as soon as possible. Admission to care is only to be used in the absence of appropriate domiciliary alternatives. However the overriding consideration is the protection of the vulnerable person.

14. Throughout the investigation there should be appropriate liaison with the Designated Officer to ensure that the investigation is progressing, that the decisions made at this stage are in line with Board/Trust policies and to fulfil any legal obligations.

15. Once the investigation is completed one of the of the following three decisions will be made by the designated officer:

    i) no further action is required;

    ii) other options should be pursued to resolve the situation;

    iii) a case conference should be convened.

The designated officer should make a detailed record of the decision and the reasons for it.

16. The Designated Officer should convene a Case Conference when one of the following occurs:

    (i) abuse is confirmed;

    (ii) there is substantial risk of abuse;

    (iii) there are suspicions of abuse and doubt remains;

    (iv) the client refuses help;

    (v) action is going to be required by more than one agency.

17. The case conference should normally take place within 7 days, but, not later than 14 days from the completion of the investigation.

18. The following staff should be invited to form the core group of the case conference:

Designated Officer
Investigating Professional
General Practitioner
Consultant Psychiatrist/Psychogeriatrician/Geriatrician or responsible Medical Officer
CPN, District Nurse (or Nursing Ward Manager)/Nurse Manager, CNMH
Police representatives (where appropriate)
Social Work Team Leader
Social Worker
Individual concerned
Advocate
Care Manager as appropriate

In addition, the Designated Officer may invite others to attend for example. Social Work Assistant, Voluntary Agency, Private Care sector, a Health Visitor, Professionals Allied to Medicine, and Approved Social Worker. Every effort should be made to involve the abused person and his/her carer or representative. The abused person's wishes with regard to other attenders should be respected. In a small number of cases it may be necessary to exclude the vulnerable person and/or the carer. The reason for exclusion should be shared with the vulnerable person and/or their carer and should be recorded.

The purpose of the case conference is to establish the potential risk to the individual and what action if any is required, including monitoring the safety of the individuals. In addition, the case conference should consider the risks which the perpetrator may pose to the vulnerable adult. The decision of the case conference may be that that no further action is required. If so, this should be clearly recorded in minutes of the meeting.

19. Having established the risks, an Agreed Protection Plan will be required. Its purpose is to minimise risk and improve the quality of life of the client. Where appropriate, there should be an agreed plan to work with the perpetrator.

20. The roles and responsibilities of each professional group will also be agreed. There should be an appropriate reporting mechanism to facilitate the sharing of information between professionals regarding the client and the perpetrator. Where the perpetrator poses a risk to others, consideration should be given to sharing this information with other professionals.

21. A date for a formal review of the action plan should be set at the case conference, although one may be called at any time where an emergency arises. The review will include inputs from the client and the professional groups which attended the initial conference and any other professional who has since become involved in the case.

22. The purpose of the review will be to establish if the risks continue to be present and if the action plan needs to be modified.

23. The minutes of the case conference should be circulated to all concerned. They will clearly outline the Action Plan, agreed roles and reporting mechanism for implementation outside of case conferences. The proposed date for review or the reason why a review is deemed to be unnecessary, should also be minuted.

24. Where the level of risk significantly diminishes, it may be decided that the case will not require further review and will therefore no longer be the subject of these procedures.

25. All decisions must be accurately recorded and reasons noted for the decision made. Each organisation should have arrangements for collating information as required by the Board/Trusts. It should also have arrangements for monitoring the implementation of its procedures.

ACCIDENT AND EMERGENCY AND HOSPITAL IN-PATIENTS

26. Where an individual who presents at an Accident and Emergency Department, or is an in-patient in either a general or psychiatric hospital, discloses that abuse has taken place at home, or where such abuse is suspected, the responsible professional should notify the line manager in accordance with the procedures.

27. The hospital Designated Officer should liaise with the appropriate Designated Officer in the community. A decision should be reached and recorded as to which of them will take the lead in the investigation. The procedures should then be followed as for abuse in a domiciliary setting.

28. Regardless of who is taking the lead, it is essential that all the professionals involved liaise effectively and that an Action plan is in place before the patient is discharged.

29. If the need for investigation arises out of office hours and is urgent, as in the case of an Accident and Emergency patient who does not require admission, the after hours duty Social Work should be contacted through Contactor's Bureau (Tel: 01232 668246).

30. ABUSE IN RESIDENTIAL/NURSING HOME/HOSTELS

Where the individual is resident in a residential or nursing home (including statutory homes), the response can be made by the management of the home who will inform the relevant person within the Trust and the Registration and Inspection Unit. The manager/proprietor will provide information on the nature of the complaint and the action they have undertaken. Any further action considered necessary by the Trust or the Registration and Inspection Unit should be undertaken within these procedures and/or 'the contract process'.

31. In general, protection of the individual and the investigation of the alleged abuse remains the responsibility of the Trusts. It is imperative that the placing Trust, host Trust and the Registration and Inspection Unit liaise to decide who should lead the investigation. The decision is to be clearly recorded with the outcome of the investigation shared with the other parties. This will assist the Registration and Inspection Unit to establish whether patterns of abuse are becoming apparent which may

have wider implications for the residents as a whole, rather than the individual resident.

32. ALLEGED ABUSE BY STAFF

Where staff have been alleged to have been the perpetrator/s of an abuse or where, on initial inquiry, there are grounds to suspect that staff may have been the perpetrator/s, it will be necessary to pursue any investigation through the staff disciplinary procedures. The primary role of the abuse procedures would then to be ensure that the alleged victim of abuse was protected from further abuse and was offered support, counselling and practical assistance.

NOTIFICATION TO POLICE

[illegible] it is suspected that a criminal offence has been or is being, or is about to be committed, the Police should be notified as soon as possible. If there is doubt that a crime has occurred, legal advice should be sought and/or the appropriate Police liaison officer should be consulted. In all circumstances the need to involve the Police should be discussed fully with the client. Where possible their agreement should be obtained.

A decision about whether the police should be notified will vary according to circumstances but the following should be considered:

1. Whether there is a legal requirement to do so. This will override all other considerations.

2. The client's expressed wish, if capable of making this judgement.

3. The assessed implications for the continuity of the relationship between the vulnerable person and the abuser.

4. Whether or not Police action will be possible eg. in the absence of a complaint.

If a police investigation is undertaken the Designated Officer will have to liaise closely with the police to:

- establish how the investigation is to be pursued;
- advise as to the services or protection that can be offered;
- advise on the implication for the client of any proposed police action.

SUMMARY

The procedures outline the steps through which the investigation progresses. At the points noted it is possible for professionals to agree that no further action is required within the full procedures. These are in effect filters to prevent every case becoming the subject of the full procedures. Professionals are encouraged to make decisions within their own competence to resolve concerns raised.

TRAINING

All providers including the independent sector should ensure that all of their employees and voluntary workers who come into contact with vulnerable adults are aware of the Board's policy and their organisation's codes of practice and procedures for responding to situations where abuse is suspected or alleged. Employees and voluntary workers should also be aware of the signs of potential abuse and know what immediate action to take.

Personnel involved in investigations and protection work will be expected to have the competence appropriate to these roles. The Board will wish to work with providers to agree competencies and standards.

It is likely that many staff and volunteers in different disciplines and work settings, will require training, ranging from awareness raising to more intensive training for specialised roles for example the interviewing of alleged perpetrators. All providers should be committed to ensuring that training is promoted as an integral part of the vulnerable adult protection strategy and, that those who work together should be facilitated to train together.

The training strategy developed should take account of the following:-

- programmes should be based on the identified needs of all relevant staff;

- all relevant staff should be trained in Vulnerable Adult Abuse Awareness, including the recognition of signs of potential abuse and what immediate action to take;

- specialist in-service training should be directed primarily to those involved in the investigation of abuse and provision of protective services and counselling services;

- a multi-disciplinary and inter-agency approach to training should be used in relation to key staff in order to create a better understanding of the roles, skills, functions and constraints for complementary professions and services.

Each provider will need to identify their training requirements and decide how these can be best met. The Board anticipates that within community Trusts the lead in providing in-service training will be taken by social services because of their role and experience in investigative and statutory work and the presence of social services training teams within the community Trusts. However, other professions, notably nursing, will have a key role in the training of staff both on a uni-disciplinary and a multi-disciplinary basis. Hospital Trusts and other providers may wish to explore the possibility of working with community Trusts in addressing their training needs. The EHSSB will undertake to

centrally organise the training for GPs. This will follow the process used to deliver the training for The Children (NI) Order 1995.

APPENDIX I

FORMS OF ABUSE AND ASSOCIATED INDICATORS
(From DHSS Guidance on Abuse of Vulnerable Adults)

The indicators listed below under each form of abuse are not exhaustive nor should they be taken as definitive proof that abuse has taken place. Many could equally indicate an alternative form of abuse or illness. There may be other indicators which should not be ignored.

The victim may be subject to a number of forms of abuse.

Adults with particular disabilities can be more susceptible to certain types of abuse than others. For example adults with a learning disability may be unwitting victims of sexual or financial abuse. Immobile adults are less able to avoid certain forms of physical abuse.

Often the victim will be too intimidated, or afraid to complain that he or she is being abused. Those with communication difficulties may be unable to make their complaints understood.

Any suggestion that all is not well should be seen as an indicator of possible abuse of one form or another.

The following should be viewed as indicators of concern and not as definitive prove that abuse has occurred.

PHYSICAL ABUSE

The consequences of physical abuse can range from mild discomfort to serious injury and even death through:

- physical assault
- deprivation of nutrition
- force feeding
- deliberate administration of inappropriate medication
- withholding prescribed medication
- over-sedation
- inappropriate restraint

INDICATORS -

Black eyes
Bite marks
Injuries not consistent with explanation given
Explanations of injuries inconsistent with medical findings

Repeated attendance at GP surgeries or Casualty Departments for injuries which are not adequately explained
Signs of malnutrition
Pressure sores
Signs of force feeding, eg., bruising around mouth
Poor safety standards
Inadequate heating
Inappropriate drug therapy
Non-treatment of illness or injury
Substance misuse
Withdrawal of supplied aids eg., hearing aid, glasses, etc.
Change in personality/behaviour

SEXUAL ABUSE

This is involvement in sexual activities to which consent has not been given or cannot be given, or which violate the social/sexual taboos of family roles, or which are against the law. Consent is the voluntary acquiescence to the sexual activity based on an adequate knowledge of its nature, purpose and consequences. Staff should have a clear understanding of the complexities involved in ascertaining someone's ability to give consent.

Sexual abuse can take many forms:

- lewd or licentious behaviour
- pornographic photography
- indecent exposure
- harassment, serious teasing or innuendo
- touching especially of breasts, genitals, anus or mouth
- penetration or attempted penetration
- masturbation of either or both persons

INDICATORS -

Signs of avoidance or fear
Pain, bruising or bleeding in the genital, vaginal or anal areas
Blood stained underclothing
Difficulty in walking/sitting
Frequency of urine
Other discharges
Venereal disease
Oral bruising or ulceration
Inappropriate relationships
Overt sexual behaviour/language
"Love" bites

Change in personality/behaviour

PSYCHOLOGICAL/EMOTIONAL ABUSE

Psychological and emotional abuse can be particularly difficult to detect. It can be inflicted by:

- intimidation, humiliation, harassment, threatening or insulting behaviour, causing fear, rejection, verbal abuse
- lack of appropriate stimulation
- denial of basic rights including choice, opinion or privacy
- overprotection - not allowed to live a normal life
- involuntary isolation

INDICATORS

Withdrawn, agitated or fearful behaviour
Isolation
Inappropriate or improper dress
Unkempt or unwashed
Overt subservience, anxious to please
Denied or unreasonably restricted access
Change in personality/behaviour

FINANCIAL ABUSE

Financial abuse is interference with or deprivation of finances by any of the following means:

- theft
- withholding money or benefits money can buy
- forced signing over of social security benefits, pensions or other property
- withdrawal of money from bank or other accounts
- deprivation of appropriate care in order to retain benefits of both cash and kind
- refusal of care because of financial cost
- blocking access to material goods
- misuse of property or finances
- inappropriate charging for services
- fraud

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APPENDIX II

LEGISLATIVE BASIS FOR INTERVENTION

AL

e is no comprehensive statutory code of law dealing with the protection of ed adults. Instead, there are a variety of provisions contained in different es and in the criminal law which are relevant. The number of such sions are substantial and comprise a wide range of Acts and Orders, of h the following section provides basis information. Whilst it is important staff have basic knowledge about what is lawful/unlawful in onships, it is crucial that they should obtain legal advice in any particular of doubt.

The Mental Health Order (NI) 1986
The Marriage Act (NI) 1954
he Marriage Act 1983
The Matrimonial Causes Order 1978
Homosexual Offences Order (NI) 1982, as amended by S.145 (3) of the Criminal Justice and Public Order Act 1994
Criminal Law Amendment Act 1885
Offences Against the Person Act 1861
Criminal Law Amendment Act (NI) 1923
The NI (Emergency Provisions) Act 1991
Prevention of Terrorism (Temporary Provisions) Act 1989
Police and Criminal Evidence (NI) Order 1989
Sexual Offences (NI) Order 1978
Enduring Power of Attorney (NI) Order 1987
Health and Personal Social Services (NI) Order 1972
Registered Homes (NI) Order 1992
Public Health Act 1967
Domestic Proceedings (NI) Order 1980
County Court (NI) Order 1980

LTS

'97

APPENDIX III

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's to Development of the Policy and Procedures

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shes to acknowledge the assistance of the SHSSB who provided document to assist with the deliberations of the group. As part he group has incorporated the EHSSB's policy on Elder Protection.

1

NORTH & WEST BELFAST HEALTH & SOCIAL SERVICES TRUST

Draft Operational Policy   OP Ref No.

Date of Issue - July 1997

TITLE: POLICY ON THE PROTECTION OF VULNERABLE ADULTS

GENERAL

This policy is intended as a guide to good practice for all Trust Personnel involved in the care of Vulnerable Adults. Reference should be made to previously issued policies/guidance notes prepared by the Department of Health and Social Services and the Eastern Health and Social Services Board. Particular reference should be made to the following:-

A. Guidance On Abuse Of Vulnerable Adults - DHSS March 1996.

B. Protection Of Vulnerable Adults - EHSSB June 1997.

POLICY

1 Referrals

1.1 Referrals received by staff should be immediately discussed with Line Manager.

1.2 If concerns arise regarding suspected, alleged or confirmed abuse and further investigation is required the Designated Officer should be contacted immediately. This may be done by telephone and should be confirmed in writing to the Designated Officer within 2 days.

1.3 Referrals of a more serious or life-threatening nature will require a rapid response by the Designated Officer and should be forwarded immediately.

1.4 Referrals received out-of-hours should be made to the Social Work Staff on duty. These staff can be reached at the Contactors Bureau (01232 668246).

Cont.

2. Investigation

2.1 The Designated Officer will receive all referrals and co-ordinate the appropriate response.

2.2 The Designated Officer will record the receipt of all referrals whether received by telephone or in writing.

2.3 The Designated Officer will ensure that referrals of a serious or life-threatening nature will be investigated immediately and that the police are informed.

2.4 The Designated Officer will ensure that all other referrals will be investigated within 72 hours.

2.5 The Designated Officer will appoint an Investigating Professional who will interview the vulnerable adult and relative/carer if appropriate. This may be done separately.

2.6 The Investigating Professional will consult with colleagues and all those who have an input into the case to obtain as much information as possible about the case. The Investigating Professional and Designated Officer should consider the need for a medical assessment and/or a psychiatric/psychogeriatric assessment.

2.7 The Designated Officer will consult with legal advisors and the police, if appropriate, before making one of the following decisions:-

(a) No further action is required.
(b) Other options to be pursued to resolve the situation.
(c) A case conference should be convened.

Any decision made should be clearly recorded.

3. Case Conference

3.1 A case conference should be convened if one of the following occur:-

(a) Abuse is confirmed.
(b) There is substantial risk of abuse.
(c) There are suspicions of abuse and doubt remains.
(d) The client/patient refuses help.
(e) Action will be required by more than one agency.

3.2 A case conference will normally be convened within 7 days and no later than 14 days from the completion of the investigation.

3.3 The Designated Officer will chair the case conference and be responsible for inviting the appropriate personnel. The client/patient and the carer, relative or representative should attend the case conference, where possible.

3.4 A protection plan will be agreed at the case conference and the roles and responsibility of the different personnel confirmed.

3.5 The case conference will be minuted and a review date agreed.

4. Residential Homes/Hostels - Statutory Sector

4.1 Cases of abuse of residents in statutory homes should be immediately referred to the Manager of the Home, who will inform the Assistant Principal Social Worker for Residential Care.

4.2 The Assistant Principal Social Worker will co-ordinate the investigation and refer the case to the Registration and Inspection Unit and the Mental Health Commission, if appropriate.

4.3 The Assistant Principal Social Worker will consider the need for referrals being made to the police and the necessity of a medical examination.

4.4 Cases of abuse should be recorded initially as an Untoward Incident and forwarded to the Chief Executive's Officer.

4.5 The Assistant Principal Social Worker will record the details of the investigation and the eventual outcome.

5. Residential/Nursing Homes - Independent Sector.

5.1 Cases of abuse of residents in independent sector homes will be investigated initially by the manager/proprietor. Information on concerns arising out of this preliminary investigation will be forwarded to the relevant Designated Officer within the Trust.

5.2 The Designated Officer will liaise with manager/proprietor of the Home, the Registration and Inspection Unit, the Mental Health Commission and the Police and Care Manager, if appropriate, during the course of the investigation.

5.3 The Designated Officer will be responsible for appointing an Investigating Professional and co-ordinating the responses of all those involved.

5.4 The Designated Officer will be responsible for recording the outcome of the investigation and agree a Protection Plan for the resident with the manager/proprietor.

5.5 In the Case of a resident whose placement is being funded by the Trust but who resides outside North & West Belfast a decision will be taken by Operations Manager/Principal Social Worker on who leads the investigation.

5.6 All such cases will require close liaison between personnel within this Trust and those of the host Trust and the Registration and Inspection Unit.

5.7 The decision on who leads the investigation and the eventual outcome should be clearly recorded.

6. Accident and Emergency and Hospital In-Patients

6.1 Cases arising in Hospitals will, in the first instance be referred to the Hospital Designated Officer.

6.2 Hospital Designated Officers will liaise closely with Community Designated Officers and agree on who will lead the investigation.

6.3 Cases arising out of hours will be referred to the duty Social Worker who can be contacted through Contactors Bureau telephone 01232 668246

NB Role and Responsibilities

(1) The Designated Officer will usually be an experienced practitioner who has the necessary authority and skills to convene and chair a case conference. In the majority of cases, the Senior Social Worker (Team Leader) will assume this role.

(2) The Investigating Professional will be an experienced practitioner who is competent in carrying out an investigation, liaising with other colleagues and agencies and responsible for direct contact with the client/patient, carer and relatives as appropriate.

The Investigating Professional will hold any relevant professional qualification and will be accountable to the Designated Officer during the course of the investigation.

Policy and Procedures

PROTECTION OF VULNERABLE ADULTS

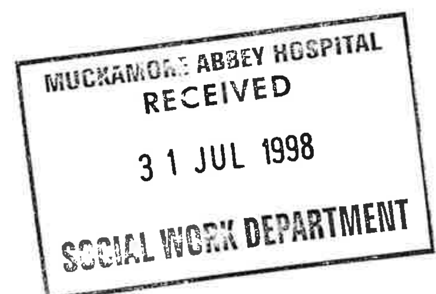
Eastern Health and Social Services Board

EASTERN HEALTH AND SOCIAL SERVICES BOARD

PROTECTION OF VULNERABLE ADULTS

POLICY AND PROCEDURES

OCTOBER 1997
SECOND EDITION



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INTRODUCTION

Health and Personal Social Services Trusts share with other agencies the responsibility of providing services to people who are vulnerable through illness, frailty or disability. Most vulnerable people are supported by committed families and other carers on a long-term basis and the question of abuse will not arise for the vast majority of these people. Much of the abuse that is reported occurs outside of a caring family environment. However, it has also to be acknowledged that the stress of caring or the complex nature of relationships between the vulnerable person and their carers can lead to abusive behaviour. This can occur within a family but also within a service or facility provided by statutory or independent providers.

Eastern Health and Social Services Board's policy for the protection of vulnerable adults has been produced in response to the Department of Health and Social Services "Guidance on Abuse of Vulnerable Adults" [(1)]. The purpose of this policy is to make clear the Board's requirement that service providers respond to situations where some form of abuse has been identified or is suspected. The policy is intended to promote good practice in responding to these situations and to provide guidance for providers in developing their practices and procedures for dealing with abuse. More specifically it will aim to prevent abuse by:

- promoting a multi-disciplinary approach to vulnerable adult protection;
- providing a basis for identifying those in need of protection;
- outlining the process of intervention;
- raising awareness of vulnerable adult abuse among professionals and the public.

POLICY

The Eastern Health and Social Services Board affirms that all vulnerable adults have the right to freedom from abuse. It expects that all agencies providing health and social services to its population will take all the necessary and appropriate measures to:

ensure that abuse does not occur within any of the services for which they are responsible;

[1)]Guidance on Abuse of Vulnerable Adults - March 1996. HPSS Management Executive Child and Community Care Directorate

BT Mod 3 Witness Stmt 20 Mar 2023 PART 4 OF 9 Exhibit Bundle (3 of 8) (T05-T06) (pp5404-8369 of 20966) (this part 2966 pages)

- respond to all cases of suspected or alleged abuse of vulnerable adults with whom they come into contact whether the source is a member of staff, a relative or any other person (this could take the form of advice, support or investigation);

- protect and support individuals where abuse is established;

- resolve the situation in which the abuse has occurred, including working with abusers;

- involve all appropriate agencies, such as the RUC and Registration and Inspection unit when necessary.

The Board requires that all cases of alleged or suspected abuse will be handled promptly and sensitively. There should be due regard for the needs and wishes of the vulnerable person, where this is consistent with the needs and rights of others who may be at risk, and the legal obligations of agencies. The primary concern should be to protect the individual and, where possible, resolve the abuse expeditiously. It is anticipated that most situations where abuse is reported or suspected will be resolved by the professional worker, usually in contact with the vulnerable person.

The procedures for dealing with abuse (see page 9-21) make provision for the initial response to be made by the person in this role. They are also designed so that, where appropriate particular cases can be resolved without implementing the procedures in full.

SCOPE OF POLICY

This policy is applicable to abuse of all vulnerable people aged 18 or over. This includes elderly people, people with a learning, physical or sensory disability and people suffering from mental illness or dementia. It covers all types of abuse, including neglect and recognises that vulnerable people cannot always protect themselves from abuse.

The policy will apply to all health and personal social services agencies providing services to vulnerable adults whether they are statutory, voluntary or private providers. This policy replaces the Board's Elder Protection Policy.

The requirements of the policy and procedures will be reflected in contracts between purchasers and providers of services. The policy will form the principles of good practice in working with vulnerable adults.

RIGHTS OF VULNERABLE ADULTS

It is recommended that all work with vulnerable adults should be underpinned with the set of values which provide and support the rights of all individuals. These are:

Privacy - the right of an individual to be left alone or undisturbed and free from intrusion or public attention into their affairs;

Dignity - recognition of the intrinsic value of people regardless of their circumstances by acknowledging their uniqueness and treating them with respect;

Independence - opportunities to act and think without reference to another person, including a willingness to incur a degree of calculated risk;

Choice - opportunity to select independently from a range of options;

Citizenship - the maintenance of all rights and duties associated with citizenship;

Fulfilment - the opportunity to pursue the realisation of personal aspirations and the recognition of his/her abilities in all aspects of daily living.

The Board believes that the application of these values to situations of potential abuse means that adults who are vulnerable have the right:

- to live safely without fear of violence or abuse in any form;
- to have their money, goods and possessions treated with respect and to receive the same protection for themselves and their property under the law as any other citizen;
- to information on, and practical help in protecting themselves from abuse;
- to be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-ridden if it is considered necessary for the safety of others, or for their own safety in circumstances where they are not competent to decide this for themselves;

- to be given information about and be supported in bringing a complaint under any existing complaints procedure; (including complaints about the investigative process or outcomes);
- to be supported in reporting the circumstances of any abuse to independent bodies, such as the Health and Social Services Council, the Mental Health Commission, the Police, the Registration and Inspection Unit and advocacy schemes;
- to have alleged, suspected or confirmed cases of abuse investigated urgently;
- to receive appropriate support, education, counselling, therapy and treatment following abuse;
- to seek redress through appropriate agencies;
- to have their nearest relative, informal carer or advocates act on their behalf, where necessary.

DEFINITION AND MAIN FORMS OF ABUSE (See Appendix 1)

The Department of Health and Social Services in its guidance on abuse of vulnerable adults defines abuse as:-

"The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependent, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship." (Page 1, DHSS 1996) [1]

The main forms which abuse can take are:-

PHYSICAL ABUSE

Physical abuse is violence, resulting in bodily harm or mental distress. It includes assault, unjustified denial of rights and restrictions of the freedom of movement. However, in some instances it can be difficult to confirm as injuries can be sustained through frailty and other medical conditions. Medical opinion may be required as not all physical signs of bruising are due to Abuse.

SEXUAL ABUSE

This is the involvement of a vulnerable person in sexual activities to which they have not consented or are unable to give consent, or that breeches the law as it effects all adults.

FINANCIAL ABUSE

This involves a theft or obtaining of money, objects or property belonging to a person, who is vulnerable. It is accomplished by withholding benefit, the use of threat of force or through misrepresentation.

[1] *Guidance on Abuse of Vulnerable Adults - March 1996. HPSS Management Executive Child and Community Care Directorate*

PSYCHOLOGICAL AND EMOTIONAL ABUSE

This is the threat of violence or isolation, including name calling and other forms of assault. It also includes denial of basic rights, inclusive of choice, opinion or privacy.

MISUSE OF MEDICATION

The administration or with-holding of medication for other than legitimate therapeutic purposes.

INSTITUTIONAL ABUSE

Institutional abuse occurs when inappropriate practices or systems are employed within facilities which deny residents rights of choice, privacy and independence, and when staff become desensitised and accept as reasonable, practices which their personal principles would lead them to question outside the establishment.

NEGLIGENCE

Negligence is the breach of duty or carelessness that results in injury to the Vulnerable person. This may include the with-holding of help in performing activities of daily living. Sometimes this form of abuse may be passive, eg., a failure to understand or respond to the implications of a medical situation. It needs to be recognised however that sometimes this lack of understanding may result from inadequate counselling, supervision and training or information.

More detailed information about abuse and associated indicators is reproduced from the Department of Health and Social Services' Guidance on Abuse of Vulnerable Adults in Appendix 1.

CONSENT

In deciding what action should be taken about alleged or suspected abuse, the issue of consent requires careful consideration. Two questions need to be addressed:

1 Did the vulnerable adult give meaningful consent to the act, relationship or situation which constitutes the abuse?

2 Do they now give meaningful consent to any preventive action, investigation or report to the police (where a crime is suspected) that may be considered necessary?

To be meaningful, consent must be freely given on the basis of knowledge and understanding. Meaningful consent cannot be determined easily and no procedure can be written that will clearly identify when it has or has not been given. Careful consideration will need to be given to a number of questions including:

- the mental capacity of the vulnerable adult;
- whether the severity or nature of their condition significantly undermines their understanding and renders them incapable of giving consent;
- whether any incapacity is temporary or permenant;
- whether unreasonable or undue pressure was applied to obtain consent;
- the legislation applicable to the giving or with holding of consent;
- whether the law permits the vulnerable adult to give consent to a particular act or relationship.

It should not be presumed that a vulnerable adult is incapable of giving consent on the grounds of a mental illness or learning disability alone. In most cases it is expected that it will be determined that the vulnerable adult is able to give meaningful consent and their wishes should be respected except where this creates a conflict with a duty to protect others or the law (see below).

Before reaching any decision about the ability of the vulnerable adult to give meaningful consent, it is essential that staff consult with their managerial and professional lines and that legal advice is obtained.

DISPENSING WITH CONSENT

There will be some circumstances in which it will be necessary to override the wishes of the vulnerable adult even though they are deemed to be capable of giving meaningful consent:

- where there is an overriding public interest, for example to prevent serious harm or injury to others;
- to prosecute a serious criminal offence. It should be noted that there is a common law duty for all citizens to report any suspected arrestable offence to the police.

As when considering the vulnerable adult's ability to give meaningful consent, there should be full discussion and reference to legal advice before any decision is made.

In all cases where the wishes of the individual are overridden, this should be fully explained to the individual and their carer or advocate when appropriate. In these cases the wishes and best interests of the individual should still receive full consideration in any decisions that are subsequently made.

CONFIDENTIALITY

"All HPSS bodies and those carrying out functions on behalf of the HPSS have a common law duty of confidence to patients and clients and a duty to support professional ethical standards of confidentiality" (Page 7 DHSS 1996).* Information given by an individual about abuse should only be disclosed to those who need it in order to plan or manage any care or treatment that the person may require. Such information should not be disclosed to any one else except where disclosure is required by law or by order of the court. It may also be necessary to disclose confidential information in order to protect others or to prosecute serious crime as discussed in the section on consent.

**The protection and Use of Patient and Client Information (DHSS 1996)*

PROCEDURES FRAMEWORK

INTRODUCTION

The procedures which follow provide a framework within which Trusts may develop their own procedures. The framework is designed to take account of:

- the range of settings in which abuse may arise;
- the different forms that abuse can take;
- the varying levels of risk and danger to the individual concerned; and
- the varying degrees of urgency which may be required in responding to referrals.

The primary purpose of these procedures is to ensure that vulnerable adults are protected from abuse and the underlying causes of abuse are addressed. They should be carried out in a way that most effectively resolves the problem raised with the minimum of disruption and delay for those involved, consistent with legal and policy requirements.

The procedures do not operate independently of others such as complaints and disciplinary procedures. These may need to take precedence over the vulnerable adult protection investigation procedures in particular cases. Where there is evidence that a criminal act has been or is about to be committed, it will be necessary to involve the police and to consult them with regard to the investigation (see Notification to Police, page 20. Any action necessary for the protection of the abused person should be taken as a matter of urgency in liaison with the police.

In applying the abuse procedures, the underlying principle should be that only action that is necessary to protect the individual (and any others who may be affected) and to resolve the situation should be taken. Ideally, abuse referrals will be resolved without recourse to the full procedures through timely and professional intervention by those workers who are close to the individual concerned. The procedures are designed to allow for matters to be resolved in the most appropriate way at any stage of the process of inquiry or investigation. It is the Board's expectation that Trusts will apply this principle to their procedures.

There are four main settings in which abuse may be identified:

- Domiciliary Settings (the individual's home)
- Day Services

- Residential and Nursing Homes
- Hospitals (including day hospitals, out-patient clinics etc).

The general approach to investigating abuse will be the same irrespective of setting. This means that within each setting the response should be appropriate to the circumstances of each case and the inquiry or investigation will follow the same broad process, with similar opportunities to resolve matters at any stage, if appropriate. However, if there is a question of staff involvement in the alleged or suspected abuse in any of these settings, the disciplinary procedures will be applied and, if any other action is considered necessary to protect the individual or to resolve the situation, full account will have to be taken of the impact on the disciplinary inquiry. Similarly, if the complaints procedure is invoked, this will become the primary means through which an inquiry is conducted. It will be necessary however, to consider any immediate protection .

The main difference that should be noted in the way the procedures operate in any of the four main settings is in the roles of the professional staff who are identified as the Designated Officer or the Investigating Professional. It will be the responsibility of each Trust to decide how these roles should be assigned.

It is possible that abuse that is identified in one setting may have its origins in another setting. For example, the first indication of someone being physically abused in their own home may be picked up at an out-patient clinic or on admission to hospital for an unrelated condition. While initial inquiries to establish the source of abuse may be carried out in the setting where it first comes to light, responsibility for any formal investigation will be decided on the basis of who is best placed to carry out an investigation. However there will be a need for very close liaison between professionals in each setting to ensure effective co-ordination of any investigation or other action. Where separate Community and Hospital Trusts are involved, formal liaison channels should be established.

ROLES

The terms of Designated Officer and Investigating Officer are used to describe specific functions within the procedures, as shown below. It is not intended that these roles should be the responsibility of any single professional group. The main consideration in assigning the roles should be the competence of the individual to carry out the associated responsibilities. It is not assumed that either of these roles will be a new post.

Designated Officer

This role requires an experienced practitioner who has expertise in the area of abuse and in the process of investigation.

As outlined in the procedures, there will be opportunities to make decisions not to proceed further with the procedures.

1. Primary in the skills required will be that of organisation. The Designated Officer will be required to co-ordinate the investigation liaise with colleagues and other organisations. They will be required to keep detailed notes of information received, decisions made and the actions taken.

2. The Designated Officer will have to have experience of assessment and planning; and have a wide knowledge of the services available locally, including those provided by other professional groups.

3. This work will require that there is an assessment of the risks involved and an ability to accept them. This may require that the Designated Officer represents the Trust in any enquiries which result from the investigation.

4. Given that Designated Officers will provide line management support to the Investigating Officer, they will need to have the skills and knowledge necessary to provide supervision.

5. They will require the skills necessary to chair case conferences where conflict may be encountered.

6. They will be aware of the legislation which applies and will keep themselves up to date on any changes.

The Designated Officer is the co-ordinating professional responsible for the continuation of the investigation. They will have sufficient authority to initiate and chair a case conference and to liaise with professional colleagues. The Designated Officer will require to be experienced within their own field ie. Elderly, Physical Disability, Learning Disability with a minimum grade of Team Leader or their equivalent. The expectation would be that it is part of the duties already undertaken by the person or persons nominated by the Trusts.

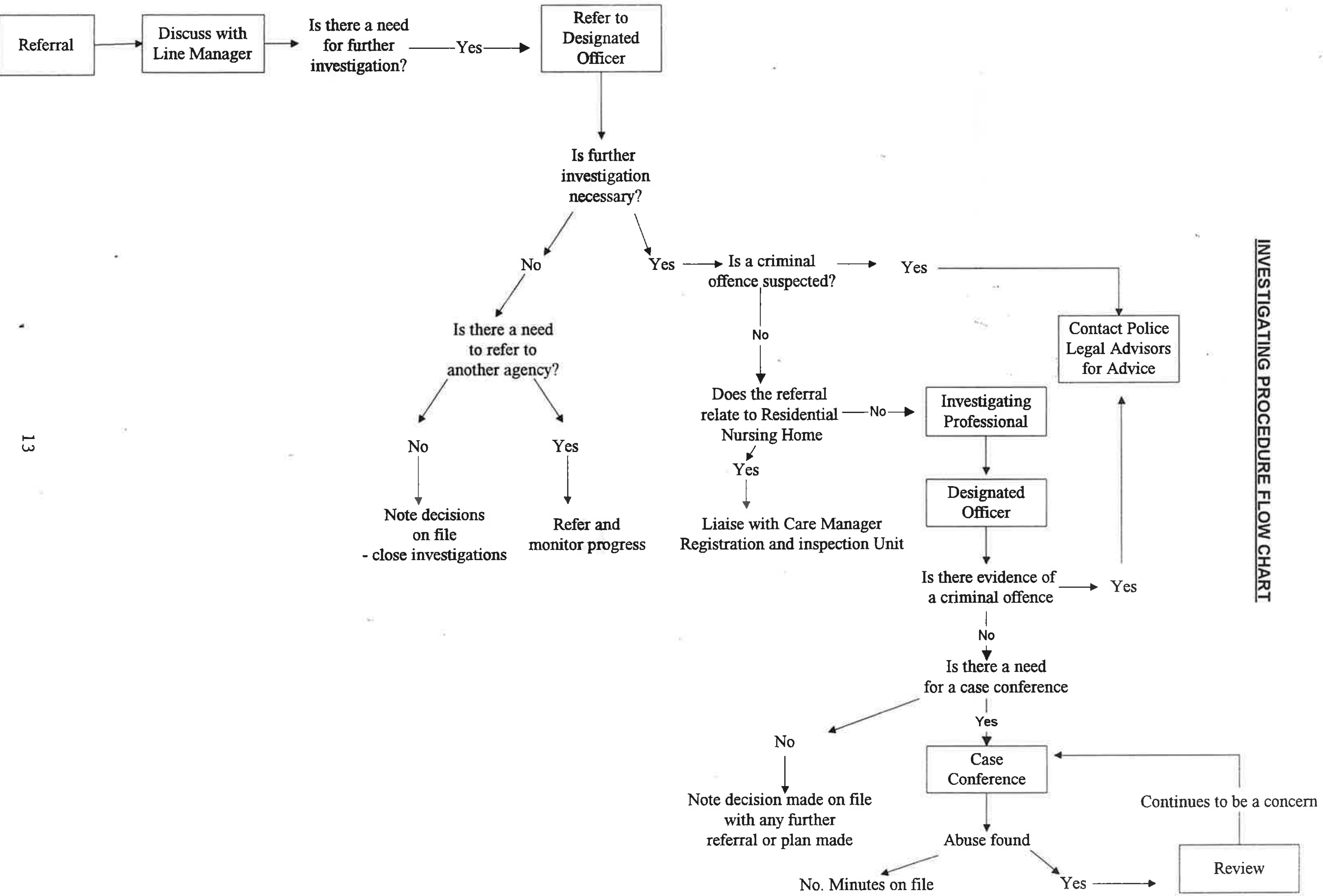
Investigating Professional

This role will require an experienced professional. They will:

- have skills in assessing, risk and the needs of clients/carers;
- plan and look at alternatives available;
- provide counselling and support;
- confront perpetrators where appropriate;
- work with perpetrators who may also be Vulnerable Adults;
- have Experience of Multi-Disciplinary working;
- be aware of the legislation which applies and will keep themselves up to date on any changes.

They will be responsible for direct contact with clients, carers or relatives involved in the case. Their role is to establish the facts, look at alternatives available and provide counselling and support. When carrying out these duties they will be line managed by the Designated Officer.

INVESTIGATING PROCEDURE FLOW CHART



PROCEDURE GUIDELINES

1. Referral may come from any person who has knowledge or a reasonable suspicion that a vulnerable adult is, or is at risk of, being abused. Everyone working with Vulnerable Adults has a duty to report suspected, alleged or confirmed incidences of abuse.

2. Any member of staff from the Trust, voluntary or private agency involved with vulnerable people, who receives information about alleged abuse from an identified member of the general public, or anonymously, should obtain as much information as possible from the referrer. They should treat the information in the same manner as if he/she had originated it. Where there has not been previous contact with the vulnerable person, the normal referral details, name, address, age, GP, etc. would also be required.

3. Any member of staff of the Trust should, on suspicion of abuse or on receipt of such information, immediately inform his/her line manager. Where the abuse relates to the line manager they should inform a more senior manager, in accordance with individual professional/agency guidelines. All staff working with vulnerable adults should be given guidance by their employer, on referring suspected abuse. This guidance should take account of whether the abuser is a member of staff, a family member or informal carer, visitor or any other person. It should also require staff to seek as much information and advice is as necessary to make an informed judgement about the need to refer for investigation, eg. in the case of bruising, medical opinion should be sought, as not all physical signs of bruising are due to abuse.

4. The judgements made at this stage can be the subject of consultation with fellow professionals, or the Designated Officer. However, any decisions made should be within the professional competence of those involved. Taking the example quoted of bruising, the decision not to proceed would be on medical advice and guidance, probably from a GP. This advice should be clearly noted on the client file. In any record keeping it should be borne in mind that they may be used as evidence.

5. In all instances where an investigation is not pursued, the reasons for this decision, the personnel involved and any contrary advice should be clearly noted. The file note should be signed by the professional involved and countersigned by the line manager. Where there is a difference of opinion as to whether the investigation should be pursued, the line manager should consult with the appropriate Designated Officer.

6. All referrals for further investigation should be made to the appropriate Designated Officer. This contact may be made by telephone in the first

instance If the referral is from a professional or agency involved with vulnerable adults it should be confirmed within 2 working days. In the absence of the Designated Officer arrangements should be made for the receipt of referrals. Outside normal office hours, referrals should be made to the Social Work staff undertaking after-hours duty. These staff can be reached through the Contractor's bureau (01232-668246).

7. The Designated Officer should record telephone referrals. If the referral is from a member of the public, he/she should ascertain whether the person who originated the referral is willing to be identified as the referrer. In addition the Designated Officer should, where appropriate, inform the Police and confirm this in writing within 2 working days. (See Notification to Police page 20). They should also establish whether the vulnerable adult is aware of the referral.

8. When deciding the level of urgency of any referral, the degree of apparent risk, rather than the type of abuse, will be the deciding factor. Some cases of abuse will need a rapid response and service provision must allow for this. Life threatening situations, such as severe physical abuse, require an immediate response. In all other circumstances allegations of abuse should be the subject of an initial investigation within 72 hours.

9. Having gathered what information is available and consulted if appropriate with the Police, Legal Advisors or senior colleagues, the Designated Officer can make one of three decisions.

   i) that no further action is required under the procedures for example where the referrer can resolve the presenting problem

   ii) that other options are available, which may provide a solution such as referral to other professionals.

   iii) that further investigation is required for example where there is no obvious solution.

   This decision should be clearly recorded with notes on the reason for making the decision.

10. The Investigating Professional will interview the vulnerable adult and any carer/relative separately. The process of investigation may take several interviews. The needs of the vulnerable adult, carer or carers and, where appropriate, the alleged abuser should be considered. Investigations need to be handled with the utmost sensitivity, recognising that both parties may have a continuing relationship into the future. The vulnerable person may wish to have someone else present during the interview - a carer, friend, independent advocate or

another member of staff. This should be facilitated where possible. There may also be the need to have an interpreter where communication difficulties arise.

11. Where physical, sexual or financial abuse has taken place, the individual should be informed of his/her rights to protection under law, for example to inform the Police of theft, fraud or assault. This would be particularly the case where an individual does not suffer from any form of mental disorder. If dementia, learning disability, brain injury or mental illness is a factor, a professional judgement will have to be made as to how these matters should be dealt with. The advice of the Psychiatrist/ Psychogeriatrician should be sought.(see consent page 7)

12. Where abuse has been suspected the Investigating Professional must take immediate preventive action, while recognising the vulnerable adult's right to refuse protection. In any case of physical or other forms of abuse, a complete medical assessment should be offered. Where there are other forms of abuse, the need for a medical assessment should be considered. While a competent vulnerable person may refuse protection, it is the duty of the Investigating Professional to actively encourage the person to participate in an action plan to prevent recurrence of the abuse.

13. Immediate action should include the consideration of the provision of domiciliary supports to reduce the immediate risks, alternative accommodation for the vulnerable adult or, where appropriate, the abuser. In these circumstances the existing procedures for emergency admission to a hostel, residential or nursing home should be followed and a full assessment of need undertaken, as soon as possible. Admission to care is only to be used in the absence of appropriate domiciliary alternatives. However the overriding consideration is the protection of the vulnerable person.

14. Throughout the investigation there should be appropriate liaison with the Designated Officer to ensure that the investigation is progressing, that the decisions made at this stage are in line with Board/Trust policies and to fulfil any legal obligations.

15. Once the investigation is completed one of the of the following three decisions will be made by the designated officer:

    i) no further action is required;

    ii) other options should be pursued to resolve the situation;

    iii) a case conference should be convened.

The designated officer should make a detailed record of the decision and the reasons for it.

16. The Designated Officer should convene a Case Conference when one of the following occurs:

    (i) abuse is confirmed;

    (ii) there is substantial risk of abuse;

    (iii) there are suspicions of abuse and doubt remains;

    (iv) the client refuses help;

    (v) action is going to be required by more than one agency.

17. The case conference should normally take place within 7 days, but, not later than 14 days from the completion of the investigation.

18. The following staff should be invited to form the core group of the case conference:

    Designated Officer
    Investigating Professional
    General Practitioner
    Consultant Psychiatrist/Psychogeriatrician/Geriatrician or responsible Medical Officer
    CPN, District Nurse (or Nursing Ward Manager)/Nurse Manager, CNMH
    Police representatives (where appropriate)
    Social Work Team Leader
    Social Worker
    Individual concerned
    Advocate
    Care Manager as appropriate

    In addition, the Designated Officer may invite others to attend for example. Social Work Assistant, Voluntary Agency, Private Care sector, a Health Visitor, Professionals Allied to Medicine, and Approved Social Worker. Every effort should be made to involve the abused person and his/her carer or representative. The abused person's wishes with regard to other attenders should be respected. In a small number of cases it may be necessary to exclude the vulnerable person and/or the carer. The reason for exclusion should be shared with the vulnerable person and/or their carer and should be recorded.

The purpose of the case conference is to establish the potential risk to the individual and what action if any is required, including monitoring the safety of the individuals. In addition, the case conference should consider the risks which the perpetrator may pose to the vulnerable adult. The decision of the case conference may be that that no further action is required. If so, this should be clearly recorded in minutes of the meeting.

19. Having established the risks, an Agreed Protection Plan will be required. Its purpose is to minimise risk and improve the quality of life of the client. Where appropriate, there should be an agreed plan to work with the perpetrator.

20. The roles and responsibilities of each professional group will also be agreed. There should be an appropriate reporting mechanism to facilitate the sharing of information between professionals regarding the client and the perpetrator. Where the perpetrator poses a risk to others, consideration should be given to sharing this information with other professionals.

21. A date for a formal review of the action plan should be set at the case conference, although one may be called at any time where an emergency arises. The review will include inputs from the client and the professional groups which attended the initial conference and any other professional who has since become involved in the case.

22. The purpose of the review will be to establish if the risks continue to be present and if the action plan needs to be modified.

23. The minutes of the case conference should be circulated to all concerned. They will clearly outline the Action Plan, agreed roles and reporting mechanism for implementation outside of case conferences. The proposed date for review or the reason why a review is deemed to be unnecessary, should also be minuted.

24. Where the level of risk significantly diminishes, it may be decided that the case will not require further review and will therefore no longer be the subject of these procedures.

25. All decisions must be accurately recorded and reasons noted for the decision made. Each organisation should have arrangements for collating information as required by the Board/Trusts. It should also have arrangements for monitoring the implementation of its procedures.

ACCIDENT AND EMERGENCY AND HOSPITAL IN-PATIENTS

26. Where an individual who presents at an Accident and Emergency Department, or is an in-patient in either a general or psychiatric hospital, discloses that abuse has taken place at home, or where such abuse is suspected, the responsible professional should notify the line manager in accordance with the procedures.

27. The hospital Designated Officer should liaise with the appropriate Designated Officer in the community. A decision should be reached and recorded as to which of them will take the lead in the investigation. The procedures should then be followed as for abuse in a domiciliary setting.

28. Regardless of who is taking the lead, it is essential that all the professionals involved liaise effectively and that an Action plan is in place before the patient is discharged.

29. If the need for investigation arises out of office hours and is urgent, as in the case of an Accident and Emergency patient who does not require admission, the after hours duty Social Work should be contacted through Contactor's Bureau (Tel: 01232 668246).

ABUSE IN RESIDENTIAL/NURSING HOME/HOSTELS

30. Where the individual is resident in a residential or nursing home (including statutory homes), the response can be made by the management of the home who will inform the relevant person within the Trust and the Registration and Inspection Unit. The manager/proprietor will provide information on the nature of the complaint and the action they have undertaken. Any further action considered necessary by the Trust or the Registration and Inspection Unit should be undertaken within these procedures and/or 'the contract process'.

31. In general, protection of the individual and the investigation of the alleged abuse remains the responsibility of the Trusts. It is imperative that the placing Trust, host Trust and the Registration and Inspection Unit liaise to decide who should lead the investigation. The decision is to be clearly recorded with the outcome of the investigation shared with

the other parties. This will assist the Registration and Inspection Unit to establish whether patterns of abuse are becoming apparent which may have wider implications for the residents as a whole, rather than the individual resident.

ALLEGED ABUSE BY STAFF

32. Where staff have been alleged to have been the perpetrator/s of an abuse or where, on initial inquiry, there are grounds to suspect that staff may have been the perpetrator/s, it will be necessary to pursue any investigation through the staff disciplinary procedures. The primary role of the abuse procedures would then to be ensure that the alleged victim of abuse was protected from further abuse and was offered support, counselling and practical assistance.

NOTIFICATION TO POLICE

If it is suspected that a an arrestable criminal offence has been, or is being, or is about to be committed, the Police should be notified as soon as possible. If there is doubt that a crime has occurred, legal advice should be sought and/or the appropriate Police liaison officer should be consulted. In all circumstances the need to involve the Police should be discussed fully with the client. Where possible their agreement should be obtained.

A decision about whether the police should be notified will vary according to circumstances but the following should be considered:

1. Whether there is a legal requirement to do so. This will override all other considerations.

2. The client's expressed wish, if capable of making this judgement.

3. The assessed implications for the continuity of the relationship between the vulnerable person and the abuser.

4. Whether or not Police action will be possible eg. in the absence of a complaint.

If a police investigation is undertaken the Designated Officer will have to liaise closely with the police to:

- establish how the investigation is to be pursued;
- advise as to the services or protection that can be offered;
- advise on the implication for the client of any proposed police action.

SUMMARY

The procedures outline the steps through which the investigation progresses. At the points noted it is possible for professionals to agree that no further action is required within the full procedures. These are in effect filters to prevent every case becoming the subject of the full procedures. Professionals are encouraged to make decisions within their own competence to resolve concerns raised.

TRAINING

All providers including the independent sector should ensure that all of their employees and voluntary workers who come into contact with vulnerable adults are aware of the Board's policy and their organisation's codes of practice and procedures for responding to situations where abuse is suspected or alleged. Employees and voluntary workers should also be aware of the signs of potential abuse and know what immediate action to take.

Personnel involved in investigations and protection work will be expected to have the competence appropriate to these roles. The Board will wish to work with providers to agree competencies and standards.

It is likely that many staff and volunteers in different disciplines and work settings, will require training, ranging from awareness raising to more intensive training for specialised roles for example the interviewing of alleged perpetrators. All providers should be committed to ensuring that training is promoted as an integral part of the vulnerable adult protection strategy and, that those who work together should be facilitated to train together.

The training strategy developed should take account of the following:-

- programmes should be based on the identified needs of all relevant staff;
- all relevant staff should be trained in Vulnerable Adult Abuse Awareness, including the recognition of signs of potential abuse and what immediate action to take;
- specialist in-service training should be directed primarily to those involved in the investigation of abuse and provision of protective services and counselling services;
- a multi-disciplinary and inter-agency approach to training should be used in relation to key staff in order to create a better understanding of the roles, skills, functions and constraints for complementary professions and services.

Each provider will need to identify their training requirements and decide how these can be best met. The Board anticipates that within community Trusts the lead in providing in-service training will be taken by social services because of their role and experience in investigative and statutory work and the presence of social services training teams within the community Trusts. However, other professions, notably nursing, will have a key role in the training of staff both on a uni-disciplinary and a multi-disciplinary basis. Hospital Trusts and other providers may wish to explore the possibility of working with community Trusts in addressing their training needs. The EHSSB will undertake to centrally organise the training for GPs. This will follow the process used to deliver the training for The Children (NI) Order 1995.

APPENDIX I

FORMS OF ABUSE AND ASSOCIATED INDICATORS
(From DHSS Guidance on Abuse of Vulnerable Adults)

The indicators listed below under each form of abuse are not exhaustive nor should they be taken as definitive proof that abuse has taken place. Many could equally indicate an alternative form of abuse or illness. There may be other indicators which should not be ignored.

The victim may be subject to a number of forms of abuse.

Adults with particular disabilities can be more susceptible to certain types of abuse than others. For example adults with a learning disability may be unwitting victims of sexual or financial abuse. Immobile adults are less able to avoid certain forms of physical abuse.

Often the victim will be too intimidated, or afraid to complain that he or she is being abused. Those with communication difficulties may be unable to make their complaints understood.

Any suggestion that all is not well should be seen as an indicator of possible abuse of one form or another.

The following should be viewed as indicators of concern and not as definitive prove that abuse has occurred.

PHYSICAL ABUSE

The consequences of physical abuse can range from mild discomfort to serious injury and even death through:

- physical assault
- deprivation of nutrition
- force feeding
- deliberate administration of inappropriate medication
- withholding prescribed medication
- over-sedation
- inappropriate restraint

INDICATORS -

Black eyes
Bite marks
Injuries not consistent with explanation given
Explanations of injuries inconsistent with medical findings

Repeated attendance at GP surgeries or Casualty Departments for injuries which are not adequately explained
Signs of malnutrition
Pressure sores
Signs of force feeding, eg., bruising around mouth
Poor safety standards
Inadequate heating
Inappropriate drug therapy
Non-treatment of illness or injury
Substance misuse
Withdrawal of supplied aids eg., hearing aid, glasses, etc.
Change in personality/behaviour

SEXUAL ABUSE

This is involvement in sexual activities to which consent has not been given or cannot be given, or which violate the social/sexual taboos of family roles, or which are against the law. Consent is the voluntary acquiescence to the sexual activity based on an adequate knowledge of its nature, purpose and consequences. Staff should have a clear understanding of the complexities involved in ascertaining someone's ability to give consent.

Sexual abuse can take many forms:

- lewd or licentious behaviour
- pornographic photography
- indecent exposure
- harassment, serious teasing or innuendo
- touching especially of breasts, genitals, anus or mouth
- penetration or attempted penetration
- masturbation of either or both persons

INDICATORS -

Signs of avoidance or fear
Pain, bruising or bleeding in the genital, vaginal or anal areas
Blood stained underclothing
Difficulty in walking/sitting
Frequency of urine
Other discharges
Venereal disease
Oral bruising or ulceration
Inappropriate relationships
Overt sexual behaviour/language
"Love" bites

Change in personality/behaviour

PSYCHOLOGICAL/EMOTIONAL ABUSE

Psychological and emotional abuse can be particularly difficult to detect. It can be inflicted by:

- intimidation, humiliation, harassment, threatening or insulting behaviour, causing fear, rejection, verbal abuse
- lack of appropriate stimulation
- denial of basic rights including choice, opinion or privacy
- overprotection - not allowed to live a normal life
- involuntary isolation

INDICATORS

Withdrawn, agitated or fearful behaviour
Isolation
Inappropriate or improper dress
Unkempt or unwashed
Overt subservience, anxious to please
Denied or unreasonably restricted access
Change in personality/behaviour

FINANCIAL ABUSE

Financial abuse is interference with or deprivation of finances by any of the following means:

- theft
- withholding money or benefits money can buy
- forced signing over of social security benefits, pensions or other property
- withdrawal of money from bank or other accounts
- deprivation of appropriate care in order to retain benefits of both cash and kind
- refusal of care because of financial cost
- blocking access to material goods
- misuse of property or finances
- inappropriate charging for services
- fraud

INDICATORS

Unpaid bills
Lack of appropriate clothing
Lack of food
Unkempt appearance
Unexplained withdrawal of money from accounts
Disparity between assets and satisfactory living conditions
Inappropriate interest by family members or others in assets

NEGLECT

Neglect is the wilful failure to provide appropriate care and may include:

- failure to provide care and attention
- failure to access available support
- omission in exercise of duty to care
- provision of inappropriate care and attention
- deprivation of equipment

INDICATORS

Lack of appropriate clothing
Lack of food
Unkempt appearance
Signs of malnutrition
Inadequate heating
Lack of essential equipment
Pressure Sores
Poor hygiene

APPENDIX II

LEGISLATIVE BASIS FOR INTERVENTION

There is no comprehensive statutory code of law dealing with the protection of abused adults. Instead, there are a variety of provisions contained in different statutes and in the criminal law which are relevant. The number of such provisions are substantial and comprise a wide range of Acts and Orders, of which the following section provides basis information. Whilst it is important that staff have basic knowledge about what is lawful/unlawful in relationships, it is crucial that they should obtain legal advice in any particular case of doubt.

1. The Mental Health Order (NI) 1986
2. The Marriage Act (NI) 1954
3. The Marriage Act 1983
4. The Matrimonial Causes Order 1978
5. Homosexual Offences Order (NI) 1982, as amended by S.145 (3) of the Criminal Justice and Public Order Act 1994
6. Criminal Law Amendment Act 1885
7. Offences Against the Person Act 1861
8. Criminal Law Amendment Act (NI) 1923
9. The NI (Emergency Provisions) Act 1991
10. Prevention of Terrorism (Temporary Provisions) Act 1989
11. Police and Criminal Evidence (NI) Order 1989
12. Sexual Offences (NI) Order 1978
13. Enduring Power of Attorney (NI) Order 1987
14. Health and Personal Social Services (NI) Order 1972
15. Registered Homes (NI) Order 1992
16. Public Health Act 1967
17. Domestic Proceedings (NI) Order 1980
18. County Court (NI) Order 1980

APPENDIX III

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The group wishes to acknowledge the assistance of the SHSSB who provided drafts of their document to assist with the deliberations of the group. As part of this work the group has incorporated the EHSSB's policy on Elder Protection.

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL

HEALTH AND SOCIAL SERVICES TRUST

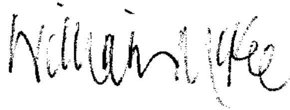
TRUST POLICY

PROTECTION OF VULNERABLE ADULTS

TP 5/98

POLICY STATEMENT

It is the decision of the Royal Hospitals to adopt the policy of the Eastern Health and Social Services Board on Protection of Vulnerable Adults 1997[1]. Training and documentation will be provided for all staff concerned with the implementation of this policy.



W S McKee
Chief Executive
April 1998

Reference

(1) EH&SSB Policy and Procedures, Protection of Vulnerable Adults.

Appendix (1)

VULNERABLE ADULTS REFERRAL PROCEDURE

In all cases the hospital referral form should be forwarded to:-

Assistant Principal Social Worker
Social Services Department
Level 5
OPC
Ext: 4287

The Assistant Principal Social Worker will be responsible for identifying a Designated Officer.

THE ROYAL HOSPITALS

Referral Form for Vulnerable Adults (Appendix II)

Name: ____________________

Address: ____________________

____

____

DOB: ____________________

GP: ____________________

Next of Kin: ____________________

Inpatient/Outpatient/Other
(e.g. Relative/Carer/ of Patient): ____________________

____

Ward/Clinic: ____________________

Consultant: ____________________

Reason For Referral

Source of Information

Is individual aware that referral is being made Yes/No

Comment

Name: ______________________________

Signature ______________________________

Designation ______________________________

Date: ______________________________

For Social Services Use Only

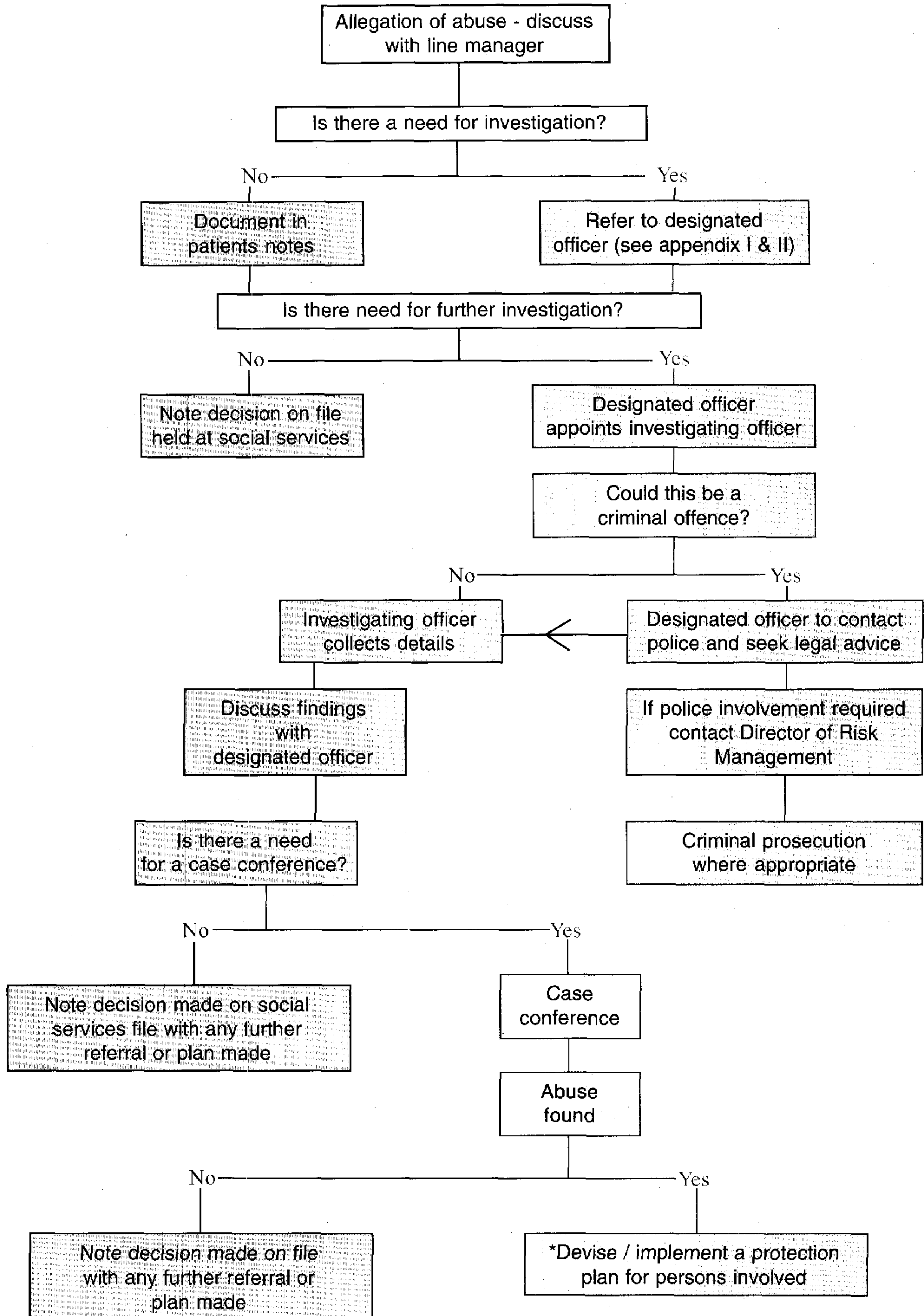
Designated Officer: ______________ Date: ______________

Investigating Officer: ______________ Date: ______________

Outcome: ______________

Date: ______________

Action to be taken following allegation of abuse



No secrets:

Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

Foreword

There can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults. The Government's White Paper, 'Modernising Social Services', published at the end of 1998, signalled our intention to provide better protection for individuals needing care and support. This is being taken up through the Care Standards Bill.

We are also committed to providing greater protection to victims and witnesses, and the Government is actively implementing the measures proposed in 'Speaking Up for Justice', the report on the treatment of vulnerable or intimidated witnesses in the criminal justice system. That report recognised that there were concerns about both the identification and reporting of crime against vulnerable adults in care settings, and endorsed the proposals made by the Association of Directors of Social Services, and others, that a national policy should be developed for the protection of vulnerable adults. It was agreed that local multi-agency codes of practice would be the best way forward.

The development of these codes of practice should be co-ordinated locally by each local authority social services department. To support this process this guidance is being issued under Section 7 of the Local Authority Social Services Act 1970. Government departments have worked closely together on the preparation of this guidance and we commend it to local authority social services departments, the police service, and the health service. It will also be of interest to the independent sector, as well as users and carers.

John Hutton
Department of Health

John Denham
Department of Health

Charles Clarke
Home Office

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Acknowledgeme

This guidance has been produced by a Steering Group, led by **Peter Dunn of the Department of Health** (DH) Social Care Group, which included representatives from a wide range of organisations. Membership of the steering group is given in Appendix I and the DH thanks all those listed for their invaluable contribution.

Annette Young
Consultant in the Management of Health and Social Care Services.

INTRODUCTION

1.1 In recent years several serious incidents have demonstrated the need for immediate action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support. The Government gives a high priority to such action and sees local statutory agencies and other relevant agencies as important partners in ensuring such action is taken wherever needed. This guidance builds on the Government's respect for human rights and results from its firm intention to close a significant gap in the delivery of those rights alongside the coming into force of the Human Rights Act 1998.

1.2 The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse. The circumstances in which harm and exploitation occur are known to be extremely diverse, as is the membership of the at-risk group. The challenge has been to identify the next step forward in responding to this diversity.

1.3 This guidance is issued in furtherance of the Government's commitment to develop such policies at national and local level. It is commended to all commissioners and providers of health and social care services including primary care groups, regulators of such care services and appropriate criminal justice agencies. These statutory agencies should work together in **partnership** (as advocated in the Health Act 1999) to ensure that appropriate policies, procedures and practices are in place and implemented locally. They should do so in collaboration with all agencies involved in the public, voluntary and private sectors and they should also consult service users, their carers and representative groups.

1.4 Local authority social services departments should play a co-ordinating role in developing the local policies and procedures for the protection of vulnerable adults from abuse. Social services departments should note that this guidance is issued under Section 7 of the Local Authority Social Services Act 1970, which requires local authorities in their social services functions to act under the general guidance of the Secretary of State. As such, this document does not have the full force of statute, but should be complied with unless local circumstances indicate exceptional reasons which justify a variation.

1.5 This document gives guidance to local agencies who have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse. It offers a structure and content for the development of local **inter-agency policies, procedures and joint protocols** which will draw on good practice nationally and locally. **Coherent strategies** should be developed, in all areas of the country, by all the statutory, voluntary and private agencies that work with vulnerable adults.

1.6 **Structure of this document.** Section 2 covers issues of definition. Sections 3, 4, 5 and 6 provide guidance about the protection from abuse of vulnerable adults by the creation of a multi-agency administrative framework (Section 3), the development of inter-agency policies and strategies (Sections 4 and 5), and the formulation of inter-agency operational procedures designed to implement those policies when instances of abuse or suspected abuse come to light (Section 6). Section 7 discusses the provision of broader guidance for staff, users, carers and members of the public.

1.7 **When developing operational guidance, local agencies should refer to the publications dealing with the abuse of vulnerable adults which appear in Appendix II.**

2. DEFINING WHO IS AT RISK AND IN WHAT WAY

2.1 In defining abuse for the purpose of both national and local guidance it is important to clarify the following factors:

Definitions

- which adults are 'vulnerable'?
- what actions or omissions constitute abuse?
- who may be the abuser(s)?
- in what circumstances may abuse occur?
- patterns of abuse; and
- what degree of abuse justifies intervention?

2.2 **Which adults are vulnerable?** In this guidance 'adult' means a person aged 18 years or over.

2.3 The broad definition of a **'vulnerable adult'** referred to in the 1997 Consultation Paper ***Who decides?***,* issued by the Lord Chancellor's Department, is a person:

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and

* See also *Making decisions* – a report issued in the light of responses to the consultation on the Law Commission's document (1999).

who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

2.4 For the purposes of this guidance 'community care services' will be taken to include all care services provided in any setting or context.

2.5 **What constitutes abuse?** In drawing up guidance locally, it needs to be recognised that the term **'abuse'** can be subject to wide interpretation. The starting point for a definition is the following statement:

Abuse is a violation of an individual's human and civil rights by any other person or persons.

In giving substance to that statement, however, consideration needs to be given to a number of factors.

2.6 Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

2.7 A consensus has emerged identifying the following main different forms of abuse:

- **physical abuse,** including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual abuse,** including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- **psychological abuse,** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- **financial or material abuse,** including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **neglect and acts of omission,** including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and
- **discriminatory abuse,** including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

Any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance.

2.8 Incidents of abuse may be multiple, either to one person in a continuing relationship or service context, or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm. Some instances of abuse will constitute a **criminal offence**. In this respect vulnerable adults are entitled to the protection of the law in the same way as any other member of the public. In addition, statutory offences have been created which specifically protect those who may be incapacitated in various ways. Examples of actions which may constitute criminal offences are assault, whether physical or psychological, sexual assault and rape, theft, fraud or other forms of financial exploitation, and certain forms of discrimination, whether on racial or gender grounds. Alleged criminal offences differ from all other non-criminal forms of abuse in that the responsibility for initiating action invariably rests with the state in the form of the police and the Crown Prosecution Service (private prosecutions are theoretically possible but wholly exceptional in practice). Accordingly, when complaints about alleged abuse suggest that a criminal offence may have been committed it is imperative that reference should be made to the police as a matter of urgency. Criminal investigation by the police takes priority over all other lines of enquiry.

2.9 Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **institutional abuse**.

2.10 **Who may be the abuser?** Vulnerable adult(s) may be abused by a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers.

2.11 There is often particular concern when abuse is perpetrated by someone in a position of power or authority who uses his or her position to the detriment of the health, safety, welfare and general well-being of a vulnerable person.

2.12 Agencies not only have a responsibility to all vulnerable adults who have been abused but may also have responsibilities in relation to some perpetrators of abuse. The roles, powers and duties of the various agencies in relation to **the perpetrator** will vary depending on whether the latter is:

- a member of staff, proprietor or service manager;
- a member of a recognised professional group;
- a volunteer or member of a community group such as place of worship or social club
- another service user;
- a spouse, relative or member of the person's social network;
- a carer; ie: someone who is eligible for an assessment under the Carers (Recognition and Services) Act 1996;
- a neighbour, member of the public or stranger; or
- a person who deliberately targets vulnerable people in order to exploit them.

2.13 Stranger abuse will warrant a different kind of response from that appropriate to abuse in an ongoing relationship or in a care location. Nevertheless, in some instances it may be appropriate to use the locally agreed inter-agency adult protection procedures to ensure that the vulnerable person receives the services and support that they need. Such procedures may also be used when there is the potential for harm to other vulnerable people.

2.14 **In what circumstances may abuse occur? Abuse can take place in any context.** It may occur when a vulnerable adult lives alone or with a relative; it may also occur within nursing, residential or day care settings, in hospitals, custodial situations, support services into people's own homes, and other places previously assumed safe, or in public places.

2.15 Intervention will partly be determined by the environment or the context in which the abuse has occurred. Nursing, residential care homes and placement schemes are subject to regulatory controls set out in legislation and relevant guidance. Day care settings are not currently regulated in this way and require different kinds of monitoring and intervention to address similar risks. Paid care staff in domiciliary services may work with little or no supervision or scrutiny, and unregulated locations such as sheltered housing may require particular vigilance. Personal and family relationships within domiciliary locations may be equally complex and difficult to assess and intervene in.

2.16 Assessment of the environment, or context, is relevant, because exploitation, deception, misuse of authority, intimidation or coercion may render a vulnerable adult incapable of making his or her own decisions. Thus, it may be important for the vulnerable adult to be away from the sphere of influence of the abusive person or the setting in order to be able to make a free choice about how to proceed. An initial rejection of help should not always be taken at face value.

2.17 **Patterns of abuse/abusing.** Patterns of abuse and abusing vary and reflect very different dynamics. These include:

- serial abusing in which the perpetrator seeks out and 'grooms' vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial abuse;
- long term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations;
- opportunistic abuse such as theft occurring because money has been left around;
- situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour;
- neglect of a person's needs because those around him or her are not able to be responsible for their care, for example if the carer has difficulties attributable to such issues as debt, alcohol or mental health problems;
- institutional abuse which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service;
- unacceptable 'treatments' or programmes which include sanctions or punishment such as withholding of food and drink, seclusion, unnecessary and unauthorised use of control and restraint (see Harris et al 1996) or over-medication;
- failure of agencies to ensure staff receive appropriate guidance on anti-racist and anti-discriminatory practice;
- failure to access key services such as health care, dentistry, prostheses;
- misappropriation of benefits and/or use of the person's money by other members of the household;
- fraud or intimidation in connection with wills, property or other assets.

2.18 **What degree of abuse justifies intervention?** In determining how serious or extensive abuse must be to justify intervention a useful starting point can be found in ***Who decides?***. Building on the concept of 'significant harm' introduced in the Children Act, the Law Commission **suggested** that:

"'harm' should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development'."

2.19 The seriousness or extent of abuse is often not clear when anxiety is first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents or allegations with an open mind. In making any assessment of seriousness the following factors need to be considered:

- the **vulnerability** of the individual;
- the **nature and extent** of the abuse;

- the **length of time** it has been occurring;
- the **impact** on the individual; and
- the risk of **repeated or increasingly serious** acts involving this or other vulnerable adults.

2.20 What this means in practice is working through a process of assessment to evaluate:

- Is the person suffering harm or exploitation?
- Does the person suffering or causing harm/exploitation meet the NHS and Community Care Act (1990) eligibility criteria?
- Is the intervention in the best interests of the vulnerable adult fitting the criteria and/or in the public interest?
- Does the assessment account for the depth and conviction of the feelings of the person alleging the abuse?

3. SETTING UP AN INTER-AGENCY FRAMEWORK

3.1 This is an area of practice which requires partnership working between statutory agencies to create a framework of inter-agency arrangements.

3.2 Local agencies should collaborate and work together within the overall framework of DH guidance on joint working. The lead agency with responsibility for co-ordinating such activity should be the local Social Services Authority but all agencies should designate a lead officer.

3.3 **Elements of an inter-agency administrative framework.** The first step in creating the necessary framework will be to **identify all the responsible and relevant agencies, including:**

- commissioners of health and social care services;
- providers of health and social care services;
- providers of sheltered and supported housing;
- regulators of services;
- the police and other relevant law enforcement agencies (including the Crown Prosecution Service);
- voluntary and private sector agencies;
- other local authority departments, eg housing and education;
- probation departments;
- DSS Benefit Agencies;
- carer support groups;
- user groups and user-led services;

- advocacy and advisory services;
- community safety partnerships;
- services meeting the needs of specific groups experiencing violence; and
- agencies offering legal advice and representation.

3.4 **A multi-agency management committee.** To achieve effective inter-agency working, agencies may consider that there are merits in establishing a multi-agency management committee (adult protection), which is a standing committee of lead officers. Such a body should have a clearly defined remit and lines of accountability, and it should identify agreed objectives and priorities for its work. Such committees should determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress.

3.5 Experience in other areas of practice has shown that such committees are often most effective where agency boundaries are coterminous.

3.6 **Further actions in such a framework will be to:**

- **identify role, responsibility, authority and accountability** with regard to the action each agency and professional group should take to ensure the protection of vulnerable adults;
- **establish mechanisms** for developing policies and strategies for protecting vulnerable adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of service users, families and carer representatives;
- **develop procedures** for identifying circumstances giving grounds for concern and directing referrals to a central point;
- **formulate guidance** about the arrangements for managing adult protection, and dealing with complaints, grievances and professional and administrative malpractice;
- **implement equal opportunity policies and anti-discriminatory training** with regard to issues of race, ethnicity, religion, gender, sexuality, age, disadvantage and disability;
- **balance the requirements of confidentiality** with the consideration that, to protect vulnerable adults, it may be necessary to share information on a 'need-to-know basis' (bearing in mind the provisions of the Public Interest Disclosure Act 1998); and
- **identify mechanisms for monitoring and reviewing** the implementation and impact of policy.

3.7 **Roles and responsibilities within and between agencies.** When an allegation of abuse is made, the receiving agency must always notify the appropriate regulatory body, within any stipulated time limits, and also any other authority who may be using the service provider. Residential care homes are required under the Registered Homes Act 1984 (as amended in 1991) 'to notify the Registration Authority not later than 24

hours from the time of its occurrence…of any event in the home which affects the well-being of any resident', and specifically of:

- any serious injury to any person residing in the home (Regulation 14(1)(b)); and
- any event in the home which affects the well-being of any resident (Regulation 14 (1) (d)).

3.8 Local procedures should address the issues to be considered with respect to people who live in one area but for whom some responsibility, for example in relation to the NHS and Community Care Act 1990, remains with the area from which they originated (see LAC(93)7 ***Ordinary residence***). Such procedures should clearly identify the responsibilities of, and action to be taken by:

- the authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection;
- the registering body in fulfilling its regulatory function with regard to regulated establishments; and
- the placing authority's continuing duty of care to the abused person

3.9 An effective response to the abuse of vulnerable adults requires not only effective inter-agency and inter-professional collaboration but also similar collaboration at all levels within agencies. Roles and responsibilities should be clear, and collaboration should take place at all the following levels:

- **operational;**
- **supervisory line management;**
- **senior management staff;**
- **corporate/cross authority;**
- **chief officers/chief executives; and**
- **local authority members.**

3.10 **Operational level.** Operational staff are responsible for identifying, investigating and responding to allegations of abuse. There needs to be a common understanding across agencies at operational level about what constitutes abuse and what the initial response to an allegation or suspicion of abuse should be. Arrangements must be established for the contribution of each relevant agency to be co-ordinated at this level. There must be a shared understanding about assessment and investigation processes and joint arrangements for decision making.

3.11 **Supervisory line management level.** Managers with responsibility for overseeing and supervising the investigation of, and response to, adult abuse are responsible for ensuring that all appropriate agencies are involved in the investigation and the provision of support, and that good standards of practice are maintained. They will also provide the first line of negotiation if differences arise between agencies.

Arrangements must be established to enable managers in different agencies to contact each other quickly to resolve any inter-agency problems.

3.12 **Senior management level.** A senior manager should be identified in each agency to take the lead role with regard to the development of the policy and strategy, issuing operational guidance, promoting good practice, making policy recommendations to corporate management groups and negotiating with other agencies within an inter-agency framework. It is important that lead managers in different agencies should have comparable discretion and authority to make strategic and resource decisions. To achieve effective working relationships, based on trust and open communication, such managers will need to understand the organisational frameworks within which colleagues in different agencies work.

3.13 **Corporate/cross authority level.** For adult protection work to be undertaken by any agency, its role and relevance to the agency's overall function must be understood and acknowledged. To achieve this, it is recommended that lead officers from each agency should submit annual progress reports to their agency's executive management body or group to ensure that adult protection policy requirements are part of the organisation's overall approach to service provision and service development.

3.14 **Chief Officer and Chief Executive level.** It is hoped that Chief Officers and Chief Executives would contribute to national developments. Locally their role is to raise the profile, support the policy, and promote the development of initiatives to ensure the protection of vulnerable adults. Nationally, their role should include responding to, and supporting, national policy proposals. To achieve this, Chief Officers and Chief Executives should be regularly briefed on adult protection work within their agency.

3.15 As Chief Officer for the lead agency the Director of Social Services will have a particularly important role to play.

3.16 **Local authority member level.** Local authority members will need to be aware of issues relating to the protection of vulnerable adults at a strategic level as well as those relating to cases of institutional and individual abuse. At the strategic and policy level an item about the protection of vulnerable adults should be included in the annual report which chief officers are required to submit to their authority or agency. With regard to institutional and individual cases of abuse, chief officers and chief executives will need to keep authority members aware of incidents of abuse and have a mechanism for doing so.

3.17 Each agency should be clear about the relationships between agencies and the structures for accountability flowing from that. Providers of

services should be clear that their operational procedures come within the framework set by statutory agencies and should clarify how and when to report outside their own hierarchy. Voluntary organisations – whether they provide residential, day, sheltered or supported housing services or specific services relating to abuse such as advice and help lines, or information and counselling – need to clarify how their role fits alongside that of statutory agencies in relation to abuse. Staff governed by professional regulation should be told how their professional responsibilities fit into this structure and at what point they can be deemed to have fulfilled these.

3.18 **Policy and service audit*.** The multi-agency management committee should undertake (preferably annually) an audit to monitor and evaluate the way in which their policies, procedures and practices for the protection of vulnerable adults are working. For this purpose, agencies should work together. Feedback on performance to all agencies should be a key feature of the audit process.

In determining the content of the audit process agencies must incorporate the following core elements:

- an evaluation of community understanding – the extent to which there is an awareness of the policy and procedures for protecting vulnerable adults;
- links with other systems for protecting those at risk – for example, child protection, domestic violence, victim support and community safety;
- an evaluation of how agencies are working together and how far the policy continues to be appropriate;
- the extent to which operational guidance continues to be appropriate in general and, in the light of reported cases of abuse, in particular;
- the training available to staff of all agencies;
- the performance and quality of services for the protection of vulnerable adults;
- the conduct of investigations in individual cases; and
- the development of services to respond to the needs of adults who have been abused.

The above elements should form the basis for developing outcome measures which can be used by both commissioners and providers of services to monitor and evaluate service provision.

3.19 Learning from experience. Agencies should routinely gather information about:

- number and source of referrals;
- information about the abused person, such as age, client group;
- information about the perpetrator;
- number of investigations and case conferences;

Note: *Social Services Departments will need to consider how this audit fits with the annual reports of Directors of Social Services.

- monitoring of disability, gender and ethnicity;
- whether the person is already known to any agency, particularly social services, or whether it is a new referral;
- type(s) of abuse referred using commonly agreed categories as suggested in 2.7;
- location in which abuse took place;
- outcomes of investigation;
- user/carer views on how policy has worked for them.

Note: issues about anonymity, status of allegations etc must be taken into account.

4. DEVELOPING INTER-AGENCY POLICY

4.1 **Policies.** The policy for the protection of vulnerable adults from abuse should flow from respect for their rights.

The policy should include:

- the scope of the problems being addressed;
- structures for planning and decision making;
- the principles to be upheld;
- a warning about the scale of the risk of abuse of vulnerable adults and the importance of constant vigilance;
- a definition of abuse, setting out the current state of knowledge, based on the most recent research on signs/patterns of abuse and features of abusive environments; and
- a definition of those vulnerable adults to whom the policy, procedures and practice guidance refer.

It should also be:

- available in an appropriate form to families and carers (and, where appropriate, users), not only following an instance of abuse but as a matter of routine; and

- compatible with the statutory responsibilities of other agencies and to policies already in force within agencies including that relating to steps for seeking redress, such as grievance and disciplinary procedures.

4.2 Once the policy has been developed it should be ratified by chief executives/authority members of all relevant agencies.

4.3 **Principles.** In practice, this means that agencies should adhere to the following guiding principles:

(i) **actively work together** within an inter-agency framework based on the guidance in Section 3;

(ii) **actively promote** the empowerment and well-being of vulnerable adults through the services they provide;

(iii) **act in a way which supports the rights of the individual** to lead an independent life based on self determination and personal choice;

(iv) **recognise people who are unable to take their own decisions** and/or to protect themselves, their assets and bodily integrity;

(v) **recognise that the right to self determination can involve risk** and ensure that such risk is recognised and understood by all concerned, and minimised whenever possible (there should be an open discussion between the individual and the agencies about the risks involved to him or her);

(vi) **ensure the safety of vulnerable adults** by integrating strategies, policies and services relevant to abuse within the framework of the NHS and Community Care Act 1990, the Mental Health Act 1983, the Public Interest Disclosure Act 1998 and the Registered Homes Act 1984 (the provisions of which will be extended by the Care Standards Bill).

(vii) **ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help,** including advice, protection and support from relevant agencies; and

(viii) **ensure that the law and statutory requirements are known and used appropriately** so that vulnerable adults receive the protection of the law and access to the judicial process.

5. MAIN ELEMENTS OF THE STRATEGY

5.1 A strategy is a long term plan for implementing policy and for sustaining a high level of commitment to the protection of vulnerable adults in practice. It requires the following components:

- clarification of the roles and responsibilities, authority and accountability of each agency and how these will be dovetailed in any specific investigations;
- procedures for responding to concerns and referrals;
- joint protocols to govern specific areas of practice such as sharing of information or the conduct of joint interviews;
- an annual statement ***see paragraph 3.18 for links with annual reports by Directors of Social Services*** about prevention which highlights safeguards in place and indicates priorities for additional safeguards;
- a dissemination plan to ensure that information is passed on to users, carers, all relevant staff groups and the management of relevant agencies, to ensure that they are aware of the policy, understand what constitutes abuse and know how to make a referral;
- identification of matters which should be specified in contracts with independent providers and contract monitoring to enhance the safety of vulnerable people;

- a service development plan which sets out the need for specialist services generated by this work and action to be taken to ensure that a range of services is available, including refuges, counselling for vulnerable adults who have been abused, intervention for service users who may be abusing; the plan will identify resources for these services;
- the setting up and learning from a system for monitoring the volume and outcomes, impact and resource implications of adult protection work which puts in place a mechanism for auditing individual cases; and
- a training strategy for all levels of staff.

5.2 **Training for staff and volunteers.** Agencies should provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, commensurate with their responsibilities in the adult protection process. This should include:

- basic induction training with respect to awareness that abuse can take place and duty to report;
- more detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency;
- specialist training for investigators; and
- specialist training for managers.

5.3 Training should take place at all levels in an organisation and within specified time scales. To ensure that procedures are carried out consistently no staff group should be excluded. Training should include issues relating to staff safety within a Health and Safety framework. Training is a continuing responsibility and should be provided as a rolling programme. (Unit Z1 of the NVQ Training Programme is specifically aimed at care workers in the community.)

5.4 **Commissioning of services and contract monitoring.** Service commissioners, at both national and local level, should ensure that all documents, such as service specifications, invitations to tender and service contracts, fully reflect their policy for the protection of vulnerable adults and specify how they expect providers to meet the requirements of the policy. They should require that any allegation or complaint about abuse that may have occurred within a service subject to contract specifications must be brought to the attention of the contracts officer of any purchasing authority. Monitoring arrangements should include adult protection issues.

Note: Currently in terms of complaints in homes, authorities need to be aware of the requirements of the Registered Homes Act 1984.

5.5 **Confidentiality.** Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information based on the best interests of the vulnerable adult. In doing so they will need to distinguish between the principles of confidentiality designed to safeguard the best interests of the service user and those protecting other aspects of management.

5.6 The most recent discussion of all aspects of patient identifiable information and how this is to be protected is to be found in the report of the Caldicott Committee ***Report on the review of patient-identifiable information.*** That report recognises that confidential patient information may need to be disclosed in the best interests of the patient and discusses in what circumstances this may be appropriate and what safeguards need to be observed. The principles can be summarised as:

- information will only be shared on a 'need to know' basis when it is in the best interests of the service user;
- confidentiality must not be confused with secrecy;
- informed consent should be obtained but, if this is not possible and other vulnerable adults are at risk, it may be necessary to override the requirement; and
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.

5.7 Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.

5.8 Principles of confidentiality designed to safeguard and promote the interests of service users and patients should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the interests of service users and patients. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of vulnerable adults then a duty arises to make full disclosure in the public interest.

5.9 In certain circumstances it will be necessary to exchange or disclose personal information which will need to be in accordance with the Data Protection Act 1998 where this applies.

5.10 The Home Office and the Office of the Data Protection Commissioner (formerly Registrar) have issued general guidance on the preparation and use of information sharing protocols.

DEVELOPING AN INTER-AGENCY POLICY ON ABUSE OF VULNERABLE ADULTS

Strategies And Plans

Management arrangements	Roles And Responsibilities	Monitoring and Audit	Dissemination Plan	Service Development Plan	Annual statement of priorities

Procedures And Protocols

Procedures for responding in individual cases	Joint protocols of shared practice eg: confidentiality and interviewing

Guidelines And Information

Internal guidelines for staff in provider agencies	Accessible information for users/carers/members of the public

6. PROCEDURES FOR RESPONDING IN INDIVIDUAL CASES

6.1 The starting point for dealing successfully with circumstances giving ground for anxiety and allegations of the abuse of vulnerable adults must be that agencies have an organisational framework within which all concerned at the operational level understand the inter-agency policies and procedures, know their own role and have access to comprehensive guidance.

6.2 The first priority should always be to ensure the safety and protection of vulnerable adults. To this end it is the responsibility of all staff to act on any suspicion or evidence of abuse or neglect (see the Public Interest Disclosure Act 1998) and to pass on their concerns to a responsible person/agency.

6.3 **Objectives of an investigation.** The objectives of an adult abuse investigation will be to:

- establish facts;
- assess the needs of the vulnerable adult for protection, support and redress; and
- make decisions with regard to what follow-up action should be taken with regard to the perpetrator and the service or its management if they have been culpable, ineffective or negligent.

6.4 Action might be primarily supportive or therapeutic or it might involve the application of sanctions, suspension, regulatory activity or criminal prosecution, disciplinary action or de-registration from a professional body. Remember, vulnerable adults who are victims, like any other victims, have a right to see justice.

6.5 **Content of procedures.** Procedures should include:

- a statement of roles and responsibility, authority and accountability sufficiently specific to ensue that all staff understand their role and limitations;
- a statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by providing immediate protection, the machinery for initially assessing abuse and deciding when intervention is appropriate and the arrangements for reporting to the police urgently when necessary;
- a statement indicating what to do in the event of a failure to take necessary action;
- a full list of points of referral indicating how to access support, advice and protection at all times, whether in normal working hours or outside them, with a comprehensive list of contact addresses and telephone numbers, including relevant national and local voluntary bodies;
- an indication of how to record allegations of abuse, their investigation and all subsequent action;
- a list of sources of expert advice;
- a full description of channels of inter-agency communication and procedures for decision making; and
- a list of all services which might offer victims access to support or redress.

(Procedures should be evaluated annually and routinely updated to incorporate lessons from recent cases.)

6.6 Guidance should also summarise the provisions of the law – criminal, civil and statutory – relevant to the protection of vulnerable adults. This should include guidance about obtaining legal advice and access to appropriate remedies.

6.7 **Management and co-ordination of the response to the allegation of adult abuse. Procedures for receiving a referral:** Information suggesting that abuse may have occurred can come from a variety of sources. The matter may, for example, be raised by the person who is abused, a concerned relative, or a member of staff. It may come in the form of a complaint, it may be an expression of concern, or it may come to light during a needs assessment. Exceptionally, the first

notification may be made to the police, especially if the matter is very serious. The issue of handling information from an anonymous informant must also be addressed. The early involvement of the police may have benefits.

In particular:

- early referral or consultation with the police will enable them to establish whether a criminal act has been committed and this will give them the opportunity of determining if, and at what stage, they need to become involved;
- a higher standard of proof is required in criminal proceedings than in disciplinary or regulatory proceedings (where the test is the balance of probabilities);
- early involvement of the police will help ensure that forensic evidence is not lost or contaminated;
- police officers have considerable skill in investigating and interviewing and early involvement may prevent the abused adult being interviewed unnecessarily on subsequent occasions;
- police investigations should proceed alongside those dealing with the health and social care issues;
- guidance should include reference to support relating to criminal justice issues which is available locally from such organisations as Victim Support and court preparation schemes; and
- some witnesses will need protection. (Please see ***Speaking up for Justice*** (1988), including the provisions in Part II of the Youth Justice and Criminal Evidence Act 1999 – the majority of which will be implemented in the Crown Court by the end of 2000.)

This process may not always result in criminal proceedings.

6.8 All those making a complaint or allegation or expressing concern, whether they be staff, service users, carers or members of the general public, should be reassured that:

- they will be taken seriously;
- their comments will usually be treated confidentially but their concerns may be shared if they or others are at significant risk (see 5.5 to 5.10);
- if service users, they will be given immediate protection from the risk of reprisals or intimidation;
- if staff, they will be given support and afforded protection if necessary, eg: under the Public Interest Disclosure Act 1998;
- they will be dealt with in a fair and equitable manner; and
- they will be kept informed of action that has been taken and its outcome.

6.9 Information relating to alleged abuse will trigger these procedures to govern investigation and further work. In pursuance of the objectives

listed in **6.3** the following processes will need to be co-ordinated and managed, in parallel where necessary:

- investigation of the complaint;
- assessment and care planning for the vulnerable person who has been abused;
- action with regard to criminal proceedings;
- action by employers, such as, suspension, disciplinary proceedings, use of complaints and grievance procedures, and action to remove the perpetrator from the professional register;
- arrangements for treatment or care of the abuser, if appropriate; and
- consideration of the implications relating to regulation, inspection and contract monitoring.

6.10 **Investigation.** A properly co-ordinated joint investigation will achieve more than a series of separate investigations. It will ensure that evidence is shared, repeated interviewing is avoided and will cause less distress for the person who may have suffered abuse. Good co-ordination will also take into account the different methods of gathering and presenting evidence and the different requirements with regard to standard of proof. The communication needs of victims including people with sensory impairments, learning disabilities, dementia or whose first language is not English must be taken into account. Interviewers and interpreters may need specific training. The goal, as noted by the ***Independent Longcare inquiry***, should be that: “There have to be agreements on lead responsibilities, specific tasks, co-operation, communication and the best use of skill. Those interagency arrangements must be in place so that they can be activated quickly when needed. However, no individual agency’s statutory responsibility can be delegated to another. Each agency must act in accordance with its duty when it is satisfied that the action is appropriate. Joint investigation there may be but the shared information flowing from that must be constantly evaluated and reviewed by each agency”.

6.11 The procedure should be clear about the role of the regulatory authority in investigations.

6.12 Agencies receiving a complaint or allegation of abuse should inform other agencies involved of the nature of the complaint or allegation and the action being taken. The lead agency should co-ordinate and monitor action, and should ensure that other agencies involved receive updates on progress made in the investigation unless is it unsafe and inappropriate for them to do so.

6.13 The following stages of investigation of any allegation of abuse will need to be undertaken:

- **reporting** to a single referral point;

- **recording,** ***with sensitivity to the abused person,*** the precise factual details of the alleged abuse;
- **initial co-ordination** involving representatives of all agencies which might have a role in a subsequent investigation and could constitute a strategy meeting;
- **investigation** within a jointly agreed framework to determine the facts of the case; and
- **decision making** which may take place at a shared forum such as a case conference.

6.14 **Record keeping.** Whenever a complaint or allegation of abuse is made all agencies should keep clear and accurate records **and each agency should identify procedures for incorporating,** on receipt of a complaint or allegation, all relevant agency and service user records into a file to record all action taken. In the case of providers of services these should be available to service commissioners and local inspection units.

6.15 Staff need to be given clear direction as to what information should be recorded back on the user's file and in what format. The following questions will give a guide:

- what information do staff need to know in order to provide a high quality service to the person concerned?
- what information do staff need to know in order to keep people safe under the service's duty to protect vulnerable people from harm?
- what information is not necessary?
- what may be a breach of a person's legal rights?

6.16 Records should be kept in such a way that they create statistical information as a by-product.

6.17 All agencies should identify arrangements, consistent with principles of fairness, for making records available to those affected by, and subject to, investigation.

6.18 If the alleged abuser is a service user then information about his or her involvement in an adult protection investigation, including the outcome of the investigation, should be included on his or her case records. If it is assessed that the individual continues to pose a threat to other service users then this should be included in any information that is passed on to service providers.

6.19 **Assessment Planning for the person's future protection.** Once the facts have been established, an assessment of the needs of the adult abused will need to be made. This will entail joint discussion, decision and planning for the person's future protection.

6.20 In deciding what action to take, the rights of all people to make choices and take risks and their capacity to make decisions about arrangements for investigating or managing the abusive situation should be taken into account. (Note the contents of the Power of Attorney Act 1971 and the Enduring Power of Attorney Act 1995.)

6.21 The vulnerable adult's capacity is the key to action since if someone has 'capacity' and declines assistance this limits the help that he or she may be given. It will not however limit the action that may be required to protect others who are at risk of harm. In order to make sound decisions, the vulnerable adult's emotional, physical, intellectual and mental capacity in relation to self determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed (the Government's policy statement ***Making decisions*** sets out proposals for making decisions on behalf of mentally incapacitated adults).

6.22 **Person alleged to be responsible for abuse or poor practice.** When a complaint or allegation has been made against a member of staff, he or she should be made aware of his or her rights under employment legislation and internal disciplinary procedures.

6.23 In criminal law the Crown or other prosecuting authority has to prove guilt, and the defendant is presumed innocent until proved guilty.

6.24 Alleged perpetrators who are also vulnerable adults themselves, in that they may have learning disabilities or mental health problems and are unable to understand the significance of questions put to them or their replies, should be assured of their right to the support of an 'appropriate' adult whilst they are being questioned by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'appropriate' adult.

6.25 **Staff discipline and criminal proceedings.** As a matter of course allegations of criminal behaviour should be reported to the police, and agencies should agree procedures to cover the following situations:

6.26 Procedures.

- action pending the outcome of the police and the employer's investigations;
- action following a decision to prosecute an individual;
- action following a decision **not** to prosecute;
- action pending trial; and
- responses to both acquittal and conviction.

6.27 Disciplinary procedures. Employers who are also service providers or service commissioners have not only a duty to the victim of abuse but also a responsibility to take action in relation to the employee when allegations of abuse are made against him or her. Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect vulnerable adults.

6.28 With regard to abuse, neglect and misconduct within a professional relationship, some perpetrators will be governed by codes of professional conduct and/or employment contracts which will determine the action that can be taken against them. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation.

6.29 The standard of proof for prosecution is 'beyond reasonable doubt'.

6.30 The standard of proof for internal discipline is usually the civil standard of 'on the balance of probabilities'.

6.31 Suspension from duty. The employee may be suspended pending the outcome of the employer's investigation. Decisions not to suspend an employee and/or not to inform the police, must be fully documented and endorsed separately by an independent senior officer from within the investigating agency.

6.32 Role of advocates. In some cases, it will be necessary to appoint an independent advocate to represent the interests of those subject to abuse. In such cases, all agencies should set out how the services of advocates can be accessed, and the role they should take.

6.33 Decision making. Once investigations are completed, the outcome should be notified to the lead agency which should then determine what, if any, further action is necessary.

6.34 One outcome of the investigation and assessment will be the formulation of agreed action for the vulnerable adult to be recorded on his or her care plan. This will be the responsibility of the relevant agencies to implement.

This should set out:

- what steps are to be taken to assure his or her safety in future;
- what treatment or therapy he or she can access;
- modifications in the way services are provided (eg same gender care or placement);
- how best to support the individual through any action he or she takes to seek justice or redress; and
- any on-going risk management strategy required where this is deemed appropriate.

6.35 In any case of a proved complaint or allegation, particularly where this involves professional malpractice, the lead agency should ensure that relevant agencies/professional bodies are appropriately informed (the 1999 Home Office document ***Caring for young people and the vulnerable*** offers guidance for preventing abuse of trust).

6.36 The Government intends to introduce a statutory workforce ban mechanism for people found to be unsuitable to work with vulnerable adults. The Care Standards Bill (see **4.3**) sets out the basis of the mechanism which closely mirrors that in the Protection of Children Act 1999. In this system 'vulnerability' of adults is defined in relation to those services where adults are inherently at risk of harm. The new mechanism, once in operation, will complement the General Social Care Council (GSCC) and, together, they will add significant new safeguards for vulnerable people.

6.37 If the abuse has occurred within a residential unit, once the safety of the residents has been established and any immediate investigation is completed, the appropriate regulatory body (currently the LA/HA inspection unit) should establish the need for any enforcement action under the Registered Homes Act 1984 (the provisions of which are extended by the Care Standards Bill (see **4.3 vi**).

7. GETTING THE MESSAGE ACROSS

7.1 All ***commissioners*** or providers of services in the public, voluntary or private sectors, should disseminate information about the multi-agency policy and procedures. Staff should be made aware through internal guidelines of what to do when they suspect or encounter abuse of vulnerable adults. This should be incorporated in staff manuals or handbooks detailing terms and conditions of appointment and other employment procedures so that individual staff members will be aware of their responsibilities in relation to the protection of vulnerable adults. This information should emphasise that all those who express concern will be treated seriously and will receive a positive response from management.

7.2 **Rigorous recruitment practices.** In relation to certain employments, persons convicted of certain offences do not have the protection of the Rehabilitation of Offenders Act 1974.

7.3 **References.** All references, including a reference from the last employer, should be taken up before formal offers of appointment and should be provided in writing. Prospective employers including agencies should make all reasonable efforts to check that referees are bona fide and, if in doubt, should ask job applicants to provide an alternative. Please note the process of the Care Standards Bill through Parliament.

7.4 **Volunteers.** Where agencies make use of volunteers who have significant and regular contact with vulnerable people, they should undertake the same checks as they would when employing paid staff. Employers and supervisors should ensure that volunteers are fully aware of agency policy and procedures governing the protection of vulnerable adults and what they (volunteers) should do and to whom they can refer if they have any concerns.

7.5 **Internal guidelines for all staff.** Provider agencies will produce for their staff a set of ***internal guidelines*** which relate clearly to the multi-agency policy and which set out the responsibilities of all staff to operate within it. These will include guidance on:

- identifying vulnerable adults who are particularly at risk;
- recognising risk from different sources and in different situations and recognising abusive behaviour from other service users, colleagues, and family members;
- routes for making a referral and channels of communication within and beyond the agency;
- assurances of protection for whistle blowers;
- working within best practice as specified in contracts;
- working within and co-operating with regulatory mechanisms; and
- working within agreed operational guidelines to maintain best practice in relation to:
  - challenging behaviour
  - personal and intimate care
  - control and restraint
  - sexuality
  - medication
  - handling of user's money
  - risk assessment and management.

7.6 Internal guidelines should also cover the rights of staff and how employers will respond where abuse is alleged against them within either a criminal or disciplinary context.

7.7 **Information for users, carers and the general public.** Information leaflets should be produced in different, user friendly formats for service users and their carers, These should explain clearly what abuse is and also how to express concern and make a complaint. Service users and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept informed of the outcome. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

7.8 In addition agencies should produce a range of information leaflets which set out how members of the public can express concern or make a complaint if they suspect or encounter abuse of a vulnerable adult. Such information must be made available in different languages and various formats and could be lodged in public places, eg libraries and doctors' surgeries

7.9 **Direct payments.** Anyone who is purchasing his or her own services through the direct payments system and the relatives of such a person should be made aware of the arrangements for the management of adult protection in their area so that they may access help and advice through the appropriate channels. Care managers, who play a role in direct payments, could be asked to help users who are at risk of abuse.

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* DH publications are available from DH Stores, PO Box 777, London SE1 6XH

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Data Protection Act 1998

Disability Discrimination Act 1995

Disabled Persons (Services, Consultation and Representation) Act 1986

Employment Rights Act 1996

Enduring Power of Attorney Act 1995

Health Act 1999

Health Services and Public Health Act 1968

Housing Act 1985

Housing Act 1996

Human Rights Act 1998

Local Authority Social Services Act 1970

Mental Health Act 1959

Mental Health Act 1983

National Assistance Act 1948

National Health Service and Community Care Act 1990

National Health Service Act 1977

Police and Criminal Evidence Act 1970

Power of Attorney Act 1971

Public Health Acts 1936 and 1961

Public Interest Disclosure Act 1998

Registered Homes Act 1984

Registered Homes (Amendment) Act 1991

Sexual Offences Act 1956

Sexual Offences Act 1967

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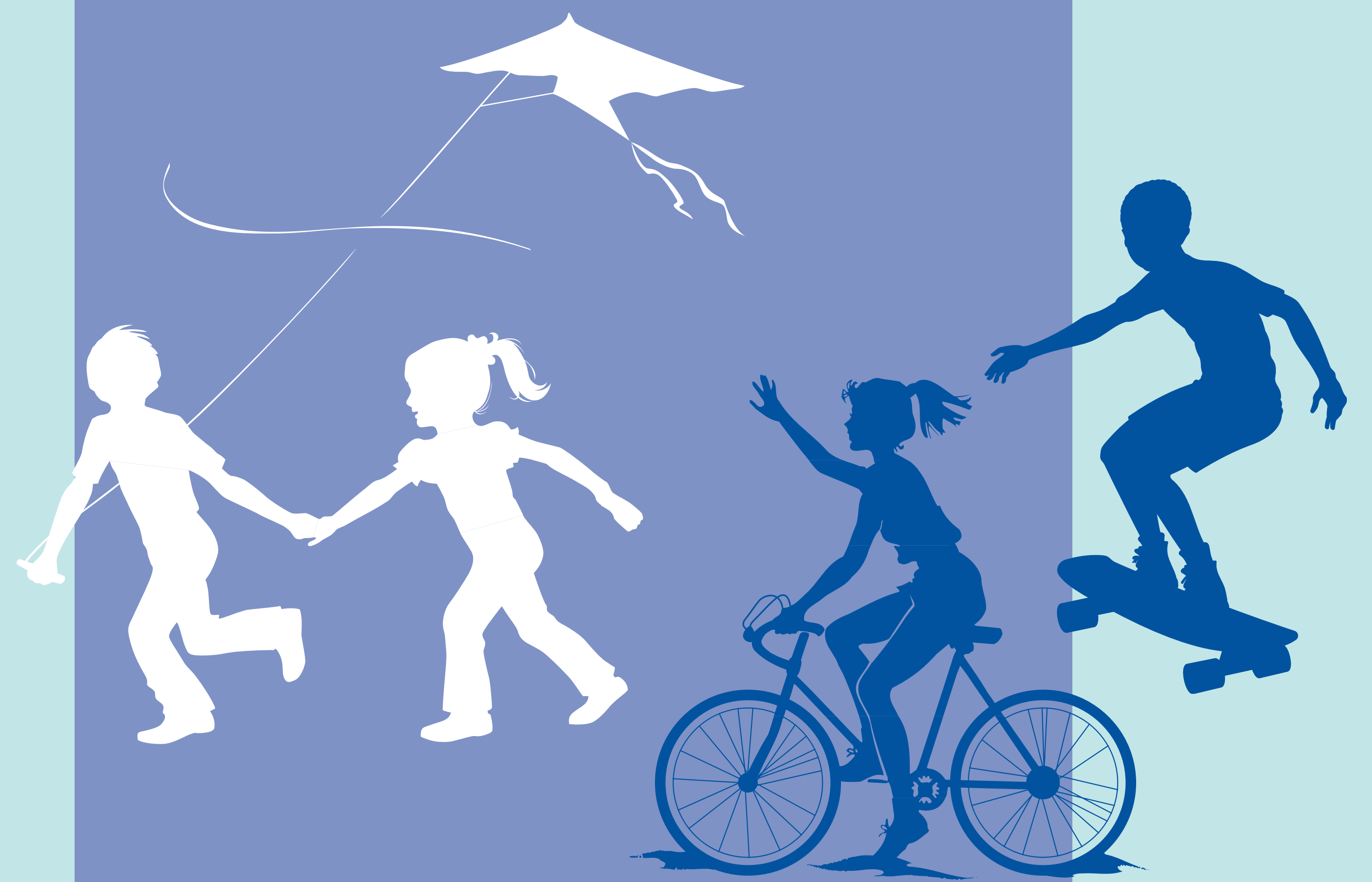

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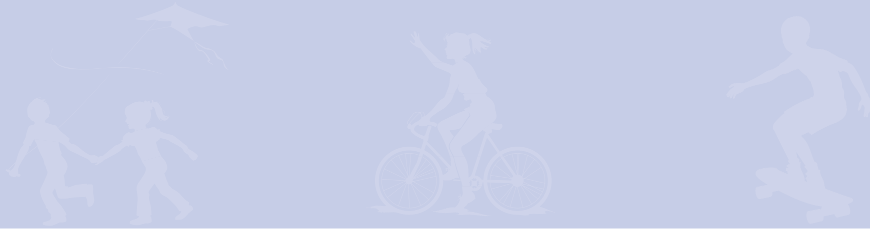
DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

CO-OPERATING TO SAFEGUARD CHILDREN



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Introduction

1

1.1 In 1980 the United Nations General Council adopted the United Nations Convention on the Rights of the Child (UNCRC). Two years later it was ratified by the United Kingdom government with some reservations in respect of youth justice, immigration and employment. The Convention covers a wide range of matters affecting children. However, Article 6 is one of the briefest but most fundamental. It states:

1) "States Parties recognize that every child has the inherent right to life
2) States Parties shall ensure to the maximum extent possible the survival and development of the child."

1.2 Article 6 constitutes an obligation in international law for governments to provide services aimed at safeguarding children from serious harm. Article 3 of the Convention, however, is more specific on what they should do.

1. "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be the primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her[1] well-being, taking into account the rights and duties of his parents, legal guardians or other individuals legally responsible for him and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in number and suitability of their staff, as well as competent supervision."

1.3 To summarise, governments are required by the UNCRC to ensure that all actions concerning a child take full account of his best interests. They must provide children with adequate care when parents or others with legal responsibility fail to discharge their duties. The obligation to provide child protection services is, therefore, based on international as well as domestic law, such as the Children (Northern Ireland) Order (1995) (The Children Order).

1.4 More recently, the Human Rights Act (1998) has incorporated the European Convention on Human Rights (ECHR) into UK law. The Convention does not specifically mention the need for child protection services, however, Article 3 states:

"Prohibition of Torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

1.5 In a recent case, the European Court held that an English local authority was in breach of Article 3 through its failure to protect five children after various reports indicating child protection concerns were made over a four-year

1 Throughout this guidance the terms he, him etc., should be construed as also meaning she, her etc.

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period. The Court found that state parties can be held responsible for inhuman or degrading treatment inflicted by individuals within their jurisdiction. It concluded that the local authority had the pow ers to protect the children and was under a positive obligation to take those steps which could reasonably be expected to avoid a real and immediate risk of ill-treatment. Although the local authority was initially justified in only providing support and assistance to the parents, it should have taken further steps to end the maltreatment of the children, given the evidence amassed. Subsequently, the European Court of Human Rights (ECHR) ordered the local authority to pay the children £350,000 compensation. This decis ion overturned previous rulings by the House of Lords that local authorities could not be held liable in such cases.

1.6 Conversely, another English local authority was held to have co ntravened Article 6 of the ECHR, that is the right to a fair trial, and Article 8, the right to respect for private and family life after it removed a child from its mother's care under a place of safety order and subsequently obtained a care order. A number of technical issues were involved, but the local authority was criticised for failing to provide the mother with details of the evidence on which it based its decision to apply for the order . If she had been informed of the evidence, which in fact was flawed, she would have had an o pportunity to refute it.

1.7 Such cases illustrate the requirement under international law f or States to provide effective services to safeguard the welfare of children and for parents to be consulted and treated fairly .

1.8 A variety of services are provided for children in need by statutory , voluntary and community agencies. They range from general support for families to formal arrangements for safeguarding children considered to be at risk of significant harm. The Department of Health publication *"Child Protection: Messages from Research" (1995)* showed that many children and families were being dealt with under the child protection arrangements, when their needs might have been better met by the provision of supportive services. In many cases it was shown that the use of child protection proced ures did not in themselves guarantee the provision of appropriate help to the child and/or the family.

1.9 The approach set out in this guidance is intended to ensure tha t:

(i) child protection services are targeted at children most in n eed of protection from serious forms of abuse;

(ii) when the provision of other services would more appropriate ly meet their needs; that families are not exposed to the stress of being the subject of child protection investigations;

(iii) resources are targeted appropriately by the agencies invol ved.

1.10 It is essential that the child protection system focuses on those children in greatest danger. An assessment system is required to distinguish these children from those whose needs could be more appropriately met by other means of help and support. This approach should not be seen as minimising the needs of children and families who require supportive services. Such services are best provided on a multi-disciplinary/agency basis co-ordinated

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through the Children & Young Persons Committees in each Board area. A systematic assessment of children and families which broadly embraces the following 3 key areas is essential:

- the child's developmental needs;
- parental capacity; and
- family and environmental factors.

1.11 This guidance is intended to assist Area Child Protection Committees (ACPCs) develop strategies, policies and procedures to safeguard children who are assessed to be at risk of significant harm. **It fully replaces** the guidance previously provided in *'Co-operating to Protect Children', i.e. Volume 6, Children Order Guidance and Regulations.*

1.12 Section 75 of the Northern Ireland Act (1998) places a duty on public authorities to promote effective equality of opportunity for all and good relations between those of different religious belief, political opinion or race. It is essential, therefore, that an equality perspective is incorporated into child protection policy and practice at all levels and at all stages.

PRINCIPLES

1.13 Strategies, policies, procedures and services to safeguard children should be based on the following principles:

- the child's welfare must always be paramount and this overrides all other considerations;
- a proper balance must be struck between protecting children and respecting the rights and needs of parents and families; but where there is a conflict, the child's interests are paramount;
- children have a right to be heard, to be listened to and to be taken seriously. Taking account of their age and understanding they should be consulted and involved in all matters and decisions which may affect their lives;
- parents/carers have a right to respect and should be consulted and involved in matters which concern their families;
- children and families have equal access to services across the region;
- actions taken to protect a child, including investigation, should not cause the child unnecessary distress or add to any damage already suffered;
- intervention should not deal with the child in isolation; the child must be considered in a family setting, with the impact of concerns also informing an assessment of the needs of other children within the family;
- where it is necessary to protect the child from abuse, alternatives should be explored which do not involve moving the child and which minimise disruption of the family;

- actions taken by agencies must be considered and well informed so that they are sensitive to and take account of the child's age, gender , stage of development, physical or mental disability, religion, culture, language, race and, in relation to adolescents, sexual orientation;
- all agencies concerned with the protection of children must wo rk together on an inter-agency basis in the best interests of children and their families;
- each agency must have an understanding of each other' s professional values and accept their respective roles, powers and responsibi lities.

A SHARED RESPONSIBILITY

1.14 The primary responsibility for safeguarding children rests with their parents, who should ensure that children are safe from danger in the home and free from risk from others. Some parents cannot always ensure this degree of safety and it may be necessary for statutory agencies to intervene to ensure that the child is adequately protected.

1.15 Safeguarding children depends upon ef fective information sharing, collaboration and understanding between families, agencies and professionals. Constructive relationships between individual wo rkers and agencies need to be supported by senior management in each agen cy.

1.16 For those children who are suf fering, or who are at risk of suf fering significant harm, multi-disciplinary/agency working is essentia l to safeguard them. The staff of all agencies should:

- be alert to potential indicators of abuse, neglect or failure to thrive;
- be alert to the risks which individual abusers, or potential abusers, may pose to children;
- share, and help to analyse information so that informed assessments can be made of each child's needs and circumstances;
- contribute to whatever actions are required to safeguard the i ndividual child and promote his welfare;
- regularly review the outcomes for the child against specific s hared objectives; and
- work in co-operation with parents, unless this is inconsistent with safeguarding the child.

Definitions

2

DEFINITION OF A CHILD

2.1 For the purpose of this guidance a child is a person under the age of 18.

TYPES OF ABUSE

2.2 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 guidance are intended to safeguard children who are at risk of significant harm because of abuse or neglect by parents, carers or others with a duty of care towards the child. For further guidance on when this guidance applies to stranger abuse see paragraphs 6.2 & 6.3.

Physical 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
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 children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Domestic violence, adult mental health problems and parental substance misuse may expose children to emotional abuse.

Sexual 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 the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.[2]

Neglect
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 foods, shelter and clothing,

2 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 purposes 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 matter 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.

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.

CONCEPT OF SIGNIFICANT HARM

2.3 The legislation defining the circumstances in which compulsory intervention in family life is justified in the best interests of children is based on the concept of "significant harm". The relevant articles in the Children Order are Articles 2(2) and 50(3). Where a Trust has reasonable cause to suspect that a child is suffering, or likely to suffer significant harm (Article 66) it is under a duty to make enquiries, or cause enquiries to be made. A court may only make a care order (committing the child to the care of the Trust) or supervision order (putting the child under the supervision of the Trust) in respect of a child if it is satisfied that:

- the child is suffering, or is likely to suffer, significant harm; and
- that the harm, or likelihood of harm, is attributable to a lack of adequate parental care or control (Article 50).

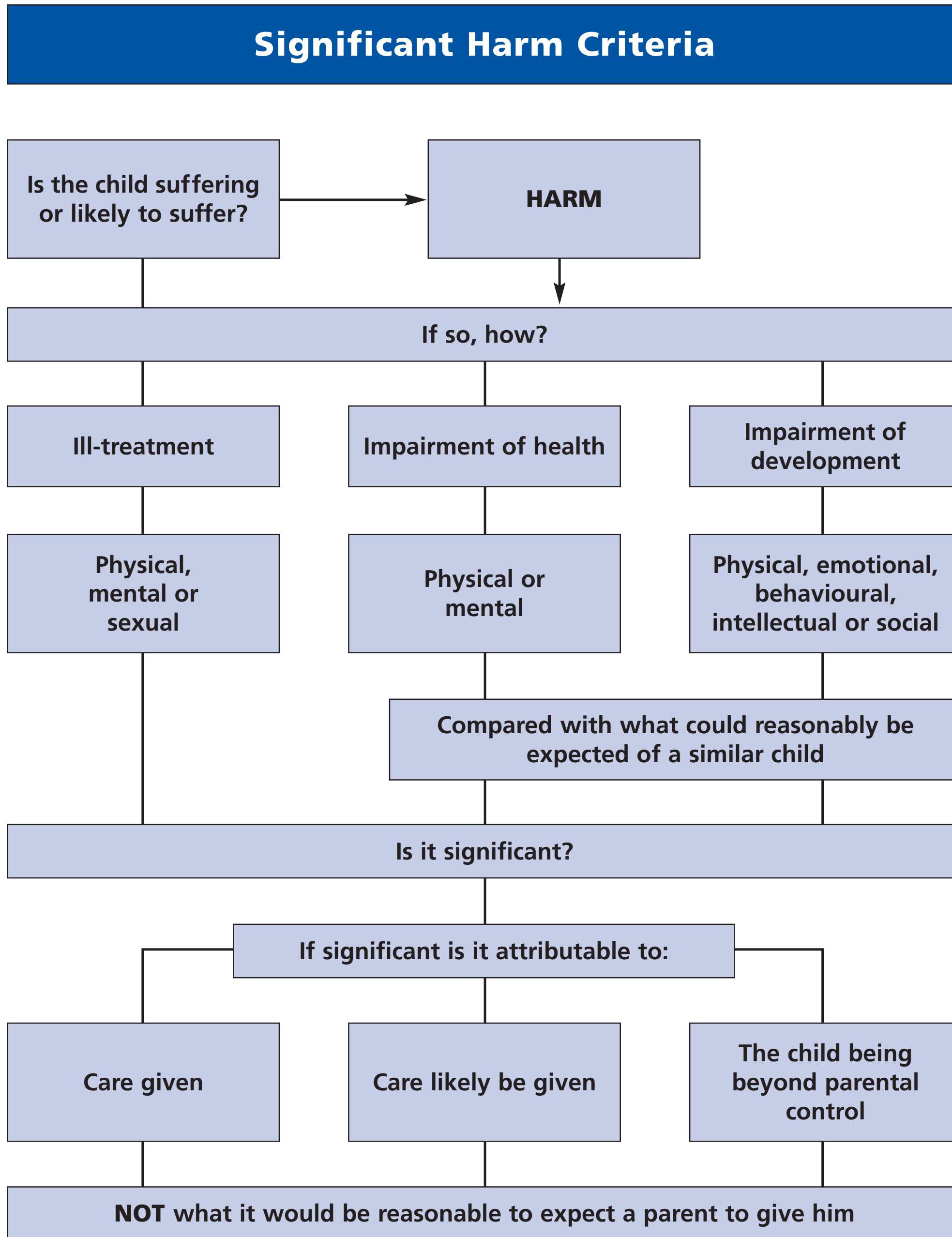
2.4 There are no absolute criteria for judging what constitutes significant harm. However, they may include the degree, extent, duration and frequency of harm. Sometimes, a single traumatic event may constitute significant harm, e.g. a violent assault, sexual assault, suffocation or poisoning. More often, significant harm is a series of events, both acute and long-standing, which interrupt, change or damage the child's physical and/or psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical and/or sexual abuse that causes impairment, sometimes to the extent of constituting significant harm.

2.5 It is important that registration should occur when the actual or likely abuse is sufficiently serious to constitute significant harm as the use of child protection procedures and the placing of a child's name on the Child Protection Register may cause considerable stress for the family involved. In making the decision it will be important to consider that harm is defined as ill-treatment or impairment of health or development. Whether it is significant is determined by the health and development of the child as compared to that which could reasonably be expected of another child (Article 50(3)).

2.6 The following diagram (taken from *Adcock.M et al. eds (1991) Significant Harm its Management and Outcome*) is helpful in determining what may constitute significant harm. The criteria of what constitutes significant harm is imprecise and demands a careful application of professional judgment along with consideration of the available evidence, concerns and matters relating to the individual child(ren) and family. In reaching the decision about registration and subsequent child protection plan, it is worth considering whether the abusive situation or the concerns are sufficiently serious to warrant the need for immediate or future care proceedings if the child protection plan proves ineffective or is difficult to fulfil.

2

Significant Harm Criteria



Roles and Responsibilities

3

INTRODUCTION

3.1 Although parents have the primary responsibility for safeguarding their children, statutory and voluntary agencies, relatives, friends and neighbours also have responsibilities. Everyone can help to safeguard children if they are alert to children's needs, and willing and able to act if they have concerns about their welfare. This chapter describes the roles and responsibilities of agencies, professionals, and the community, 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.

HEALTH AND SOCIAL SERVICES BOARDS

3.2 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 (ACPC's) - the multi-agency committee which acts as a focal point for local co-operation specifically to safeguard children considered to be at risk of significant harm (see Chapter 4).

HEALTH AND SOCIAL SERVICES TRUSTS

3.3 Where parents are unable to discharge their responsibility for their children adequately, the child's welfare becomes the corporate responsibility of the relevant Health and Social Services Trust (HSS Trust). The Trust should work in partnership with other public agencies, the voluntary sector and, where it does not compromise the well-being of children, with their parents.

ROLES AND RESPONSIBILITIES OF DIRECTORS OF HEALTH AND SOCIAL SERVICES BOARDS AND TRUSTS

3.4 On appointment a Director of a Health and Social Services Board or Trust, whether in an executive or non-executive capacity, takes on important responsibilities for the health and well-being of children in his or her area. The respective duties and legal responsibilities for HSS Boards and Trusts for children are set out in the Children (NI) Order (1995) and its associated regulations and guidance. 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.

3.5 Directors set the strategic direction of HSS Board's or Trust's services and determine policy and priorities within the overall objectives set by government. In order to do so, they need to make sure they have up-to-date and relevant information on which to base their decisions. They need to know about the services and resources for children in their area. The type and extent of information which should be available to Directors is set out in HSS Circular 2/03.

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SOCIAL SERVICES

3.6 Within HSS Trusts, social services staff provide a wide range of services for children, adults and families. The Trusts' specific legal duties for children are defined by Part IV of the Children Order for children in need and Parts V & VI for the protection of children.

CHILDREN IN NEED

3.7 Trusts have a general duty to safeguard and promote the welfare of children which should be fulfilled by social services staff providing directly, or arranging for others to provide, services designed to meet children's assessed need. Provided it is consistent with the child's welfare and safety, these services should seek to enable parents to bring up their own children. The planning and provision of these services should be done in partnership with parents, taking into account the child's age, gender, stage of development, religion, culture, language and race.

CHILD PROTECTION

3.8 Sometimes, however, there may be reason to believe that a child may be suffering, or is likely to suffer, significant harm. Under Article 66 of the Children Order, Trusts have a duty to make enquiries to enable them to decide whether they should take action to safeguard or promote the child's welfare. If there is suspicion that a crime against a child has been committed the police must be informed.

3.9 Although a child in need may not be at risk of significant harm, a child who is at risk of significant harm will always be a child in need. Therefore, social services have a responsibility for co-ordinating the assessment of the:

- child's needs;
- parents' capacity to keep the child safe and promote his welfare; and
- wider family circumstances.

3.10 Where this assessment identifies a continuing risk of harm, or likely harm, to a child, social services within the Trust are responsible for co-ordinating and implementing an inter-agency child protection plan to safeguard the child. Although the primary responsibility for fulfilling this duty lies with Trusts' social services staff, the contribution of other professions and agencies is required to do it effectively. The child protection plan should be based on the contributions of family members, professionals and agencies involved in safeguarding the child and should set out each individual's role and responsibility to the child.

3.11 In a few cases, social services, in consultation with other involved agencies and professionals, may judge that a child's welfare cannot be safeguarded if he remains at home. In these circumstances, social services may apply to a court for a care order, which commits the child to the care of the Trust. Where the child is thought to be in immediate danger, social services may apply to a court for an emergency protection order, which places the child under the protection of the Trust for a maximum of eight days.

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3.12 Because of their responsibilities, duties and powers, the Trusts' social services staff should act as the principal point of contact for children where there are child protection concerns. Arrangements should exist so that they may be contacted directly by parents or family members seeking help, concerned friends and neighbours, or by professionals and statutory and voluntary agencies.

CHILD PROTECTION PROCESSES

3.13 *Child Protection: Messages from Research (DOH 1995)* summarised the key findings from 20 research studies. A number of important themes emerged from the research about the operation of child protection processes in England & Wales:

- child protection enquiries were inappropriately used by some professionals as a means of obtaining services for children in need;
- too often, enquiries were too narrowly conducted as investigations into whether abuse or neglect had occurred, without considering the wider needs and circumstances of the child and family. Over half of the children and families who were, therefore, the subject of child protection enquiries received no services as the result of professionals' interest in their lives;
- enquiries into suspicions of child abuse can have traumatic effects on families. Good professional practice can ease parents' anxiety and lead to co-operation that helps to safeguard the child. As nearly all children who are the subject of child protection concerns remain at, or return home, involving the family in child protection processes is likely to be an effective way of promoting children's well-being;
- discussions at child protection conferences tended to focus too heavily on decisions about registration and removal, rather than focusing on future plans to safeguard the child and support the family following the conference;
- while inter-agency work was often relatively good at the early stages of enquiries, its effectiveness tended to decline once child protection plans were made, with social services left with sole responsibility for implementing the plans;
- inconsistent use was made of Child Protection Registers, which were not consulted for 60% of children for whom there were child protection concerns.

SOME IMPLICATIONS FOR POLICY AND PRACTICE

3.14 The research highlights some areas of policy and practice for consideration. They include:

Focus on outcomes for the child

- Consider what interventions are intended to achieve, and what will be the benefits to the child's long-term well-being.

- Invest sufficient time and resources across all relevant agencies in planning and implementing interventions to safeguard and promote the welfare of children at continuing risk of significant harm. Aim for good long-term outcomes in health, development and educational achievement for children about whom there are child protection concerns.

Child protection

- Promote access to a range of services for children in need without inappropriately triggering child protection processes to acquire such services.
- Consider the wider and longer term needs of children and families involved in child protection processes, whether or not concerns about abuse and/or neglect are substantiated.

Work with children and families

- Listen to children and take their views into account.
- Enable parents and other family members to be as fully involved as practicable, where this is consistent with safeguarding and promoting the child's well-being.
- Constructive and creative work with the family is crucial at all times but principally when concerns are first raised about a child's welfare. Negative initial experiences may influence parents' future relationships with professionals.
- Many families fear that revealing their problems will lead to punitive reactions by service providers. It is important to promote a positive, but realistic image, of services to encourage and enable people to gain access to the help and advice they need.
- Families need information on how to gain access to services and what to expect if and when they approach services for help.

Skilled assessment

- Look at the whole picture – not only what is currently happening to the child, but also the child's health and development, and the wider family and environmental context.
- Many factors can affect a parent's ability to care for a child, and can have an impact on children in a variety of ways, staff need to take this into account when assessing parenting capacities.
- Building on families' strengths, while addressing difficulties, should be an aim for all intervention.
- Make full use of existing sources of information, including the Child Protection Register, to ensure assessments are firmly based on facts from a range of sources.

Working across services for adults and children

- While recognising that the child's safety and welfare are paramount, give due consideration to the needs of all family members and seek appropriate assistance from other services e.g. mental health services.
- Recognise the complementary roles of adult and children's services in health and social care. For example, understanding the implications for a patient suffering from severe depression who is also a parent, should be the responsibility of both adult mental health and family and child care staff. Pool expertise to strengthen parents' capacity to respond to their children's needs, where this is in the best interests of the child.
- Professionals who work primarily with children may need training to recognise and identify parents' problems and the effects these may have on children. Equally, training for professionals working with adults should cover the impact parental problems may have on children. Joint training between adult and children's staff can be a useful means of familiarising staff with the respective needs of children and their parents.

HEALTH SERVICES

3.15 All health professionals and agencies, including those in the private sector, play an essential part in ensuring that children and families receive the care, support and services they need to promote children's health and development. The universal nature of health provision means that health professionals have an important role to play in supporting children and families in need and are often the first to be aware that families are experiencing difficulties looking after their children. The involvement of health professionals in multi-disciplinary child protection processes is important at all stages of the work with children and families through:

- recognising children at risk of significant harm;
- contributing to enquiries about a child and family;
- participating in the child protection case conference;
- contributing to planning support for children at risk of significant harm;
- providing therapeutic help to abused children;
- playing a part - through the child protection plan - in safeguarding children from significant harm; and
- contributing to case conference reviews.

MEDICAL EVALUATION OF SUSPECTED CHILD ABUSE

3.16 Medical evaluation and input to multi-disciplinary assessment must always be provided by a senior doctor with a high level of knowledge and skills in assessing child abuse and child health and development. It is essential that these professionals have received specific training regarding the arrangements for safeguarding children. In cases of possible child sexual

abuse, examination must be undertaken by a doctor with the required core and case dependent skills as defined in *"Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse"* produced jointly by The Royal College of Paediatrics and Child Health and The Association of Police Surgeons (April 2002).

BOARD DESIGNATED DOCTOR AND TRUST NAMED PAEDIATRICIAN FOR CHILD PROTECTION

3.17 Each **Health and Social Services Board** should nominate a designated doctor for child protection. Given that the doctor nominated for this role needs to have ongoing operational experience and expertise in child physical/sexual abuse, a doctor from a Trust in the Board area should normally be appointed. The role/duties include:

- membership of ACPC with responsibility for up-dating the medical components of ACPC procedures and participating in planning of multi-disciplinary training;
- advising the Board on planning, strategy, development and audit of child protection quality standards relating to both physical/sexual abuse. This should be done in conjunction with those responsible for Maternal and Child Health and Family and Child Care service planning;
- ensuring expert health advice on child protection is available to other agencies, GPs and other health professionals;
- liaising with the ACPC nursing representative and Trust named doctors for child protection;
- ensuring training in child protection issues is available for paediatricians, GPs and other doctors in regular contact with children.

3.18 Each **Health and Social Services Trust** should appoint a named paediatrician for child protection whose duties include:

- advising the Trust Chief Executive on child protection matters;
- liaising with the Trust designated nurses for child protection;
- undertaking or supervising appropriate child protection training within the Trust for all doctors in regular contact with children;
- in conjunction with designated professionals, maintaining the quality of service for their Trust via the different elements of clinical governance;
- ensuring the Trust has up-to-date guidance in place compatible with local ACPC guidelines and ensuring its dissemination;
- membership of identified ACPC working groups.

3.19 Both designated and named doctors (who may in some cases be the same person) will provide specialist 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 necessary 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. It may be appropriate to arrange for this input to be covered by an honourary contract. It is essential that sufficient resources are made available to enable staff to fulfil these roles as recommended by the Royal College of Paediatrics and Child Health Standing Committee on Child Protection (June 2000).

BOARD DESIGNATED NURSE AND TRUST NAMED NURSE FOR CHILD PROTECTION

3.20 Each **Health and Social Services Board** should nominate a designated nurse for child protection. The nurse nominated to this role needs to have a high level of skill and expertise in child protection. A nurse from a Trust in the Board area may be best placed to fulfil this function. The role /duties include:

- membership of ACPC with responsibility for up-dating the nursing components of ACPC procedures and participating in the planning of multi-disciplinary training;
- advising the Board on planning, strategy, development and audit of child protection quality standards. This should be done in conjunction with those responsible for Maternal and Child Health and Family and Child Care service planning;
- ensuring expert advice on child protection is available to nurses, other professional staff and relevant agencies;
- liaising with the Board designated doctor and Trust named nurses for child protection;
- ensuring training in child protection issues is available for nurses in regular contact with children.

3.21 Each **Health and Social Services Trust,** including hospital Trusts, should appoint a named nurse for child protection. The roles should be explicitly defined in the job description for the post. The named nurse must:

- have a high level of skill and expertise in children's health and development, child abuse and arrangements for the safeguarding of children;
- be able to give advice and guidance about child protection to all nurses in all settings in the Trust in which the nurse is employed; and
- identify the uni-disciplinary and multi-disciplinary child protection training needs of nurses. Where the need for multi-disciplinary training has been identified this should be done through the auspices of the ACPC.

3.22 It is essential that both Board designated and Trust named nurses have their time protected to enable them to fulfil the demands of their child protection roles.

HOSPITAL SERVICES

3.23 Medical, dental, nursing staff and professionals allied to medicine in hospitals need to be alert to the signs and symptoms of child abuse. They should be conscious of carers who may shop around for health services to conceal the repeated nature of their child's injuries. If a child attends regularly, even with slight injuries, they should act upon their concerns in accordance with Chapter 5 of this guidance.

3.24 Staff should know how to contact their Trust's designated professionals for advice. Specialist paediatric advice should be available at all times to Accident & Emergency (A&E) Departments, Outpatient Clinics and all wards where children receive care.

3.25 Where staff believe that a child is at immediate risk of abuse they should contact the police or social services directly and without delay.

3.26 The child's General Practitioner (GP) and health visitor should be notified immediately in writing of visits to the A&E Department made by:

- all children of 5 years and under; and
- children up to 18 years where there is cause for concern.

All visits by children to an A & E Department should be recorded in the child's hospital notes.

COMMUNITY SERVICES

3.27 Medical, dental, nursing staff and professionals allied to medicine in the community need to be alert to the signs and symptoms of child abuse. All contacts between professionals in the community and the family help to build up a picture of the child's situation. Individuals must know the process for obtaining child protection advice within their own specialism and who must be contacted. This should happen without delay. They should also know how to refer a child to social services when they are concerned about abuse or neglect, or its likelihood.

FORENSIC MEDICAL OFFICERS AND PAEDIATRICIANS

3.28 Forensic Medical Officers (FMOs) and Paediatricians have a central, co-ordinating role in examining children believed to have been abused, identifying their medical needs and, if necessary, giving evidence in court in criminal and/or care proceedings. They need to:

- know how to gather and present evidence at court; and
- understand the needs of abused children.

Where appropriate, the medical examination should be conducted jointly by an FMO and a Paediatrician. The manner in which it is carried out should form part of the healing process and should not add to the abuse. Each case will involve considerable time not only in interviewing and physical examination, but also in attending multi-disciplinary case conferences and possible court hearings.

GENERAL PRACTITIONER AND THE PRIMARY HEALTH CARE TEAM

3.29 The General Practitioner (GP) and other members of the primary health care team are well placed to recognise when a child is at risk of significant harm.

3.30 All contacts between the primary health care team and the family help to build up a picture of the child's situation and can alert the team if something is amiss. The GP and other team members should know when and how to refer a child to social services when they are concerned about abuse or neglect, or its likelihood.

3.31 The GP should be informed immediately when other members of the primary health care team become concerned about the welfare of a child. Their concerns may need to be discussed with colleagues who have experience in child protection matters where there is any clinical uncertainty. GPs should, therefore, know how to contact the Board's designated doctor for expert medical advice. Other members of the primary health care team, in fulfilling their individual professional responsibility and accountability for actions, will also need to know the processes they should follow when they have concerns about a child.

3.32 Because of their knowledge of children and families, GPs and members of the primary health care team have an important role in all stages of the child protection process, from sharing information with social services when enquiries are being made, to contributing to a child protection plan to safeguard a child. GPs should attend child protection case conferences (CPCCs) and make available relevant information about a child and family. Where a GP is unable to attend a CPCC, he or she should provide a written report containing relevant information to ensure all pertinent information is available when decisions are being made.

3.33 GPs should take part in child protection training and have regular updates as part of their postgraduate educational programme. As employers, GPs are responsible for their staff and must ensure that practice nurses, practice managers, receptionists and any other staff whom they employ, are given child protection training.

3.34 Each GP and members of the Primary Health Care Team should have access to an up to date copy of the local ACPC's procedures.

COMMUNICATION

3.35 There should be good channels of communication between GPs, health visitors, nurses who work in general practice, community nurses and midwives and other health staff about all children for whom there are concerns, or about adults who may pose a risk of harm to children.

MIDWIFE AND HEALTH VISITOR

3.36 Midwives and health visitors are well placed to identify risk factors to a child during pregnancy, birth and the child's early years.

3.37 Midwives and health visitors have an important role to play in identifying children at risk of significant harm by being alert to attitudes and behaviour during pregnancy and early parenthood which give rise to concern. They also have a crucial role in monitoring children's development and identifying that the there may be a non-organic cause for a child failing to thr ive.

3.38 Trusts should provide midwives and health visitors with clear guidelines about the action to be taken if they suspect that a child is, or is at risk of significant harm. Detailed guidance on the role of health visitors and nurses is contained in the DHSSPS *"Guidance on Professional Practice for Nurses, Midwives and Health Visitors"(1995).*

ANTENATAL CONCERNS

3.39 Midwives or health visitors caring for mothers during the anten atal period may be concerned about the future welfare of an unborn child. I f they believe the child may be at risk of significant harm they should notify social services so that the need for a pre-birth child protection case conference can be considered.

MENTAL HEALTH SERVICES

3.40 Professionals working in adult and child and adolescent mental health services may become aware of children suf fering, or likely to suffer, significant harm. They should be aware of their responsibilitie s for safeguarding children and their contribution to the child prote ction process. Although the assessment of risk to children is the responsibility of family and child care social workers, professionals in mental health servi ces have specific skills and knowledge and may be asked to contribute to investigations, advise on the effects of a parent's illness on children, or the vulnerability and risks created by a child's illness. Attendance at and written reports to child protection case conferences will be crucial and in some circums tances it may be necessary to provide evidence for the court. This will require the sharing of information where necessary to safeguard a child from significant harm.

3.41 Mental health services also have a role to play in assessing th e risk posed by perpetrators of abuse, and in providing treatment for perpetrat ors.

3.42 In assessing and/or treating children and adults in families wh ere abuse has occurred there may be a conflict between the needs of the child and the parent. The child's needs **must** be paramount. Where work is taking place in parallel with the victim and with the perpetrator, it should be co-ordinated and relevant information shared to ensure the child's well-being is safeguarded and promoted.

VISITING OF PSYCHIATRIC PATIENTS BY CHILDREN

3.43 In some parts of the United Kingdom, children visiting adult pa tients detained in psychiatric hospitals have been considered to have been placed at risk of significant harm. Hospitals should have written policie s on the arrangements for visits to patients by children. They should be drawn up in consultation with social services. Visits to patients detained under mental health legislation should only be allowed where the visit is de emed to be in the child's best interest. Decisions to allow such visits shoul d be reviewed regularly.

EDUCATION SERVICES

3.44 All schools and colleges have a pastoral responsibility towards their pupils and should take all reasonable steps to ensure that their welfare is safeguarded and their safety is preserved. All those within education services can play a part in the prevention of abuse and neglect through:

- their own policies and procedures for safeguarding children;
- the preventative curriculum; and
- identification of children suffering, or likely to suffer, significant harm.

CHILD PROTECTION POLICIES AND PROCEDURES

3.45 Teachers and others working in the education services have a significant contribution to make to the safeguarding of children. All schools and colleges should create and maintain a safe environment for children and young people. They should have a child protection policy that sets out the procedures to be followed whenever there are concerns about a child. Schools' child protection policies should also address how children will be made aware of risks, how children will be helped to recognise risks and how they will be given the skills to cope through the use of the preventative curriculum. *"Pastoral Care in Schools – Child Protection"*, (Department of Education Circular 9/99), provides detailed child protection guidance.

IDENTIFICATION OF CHILDREN AT RISK OF ABUSE

3.46 Through their day-to-day contact with pupils, staff in schools are well placed to notice outward signs of possible neglect or abuse. They should refer any concerns to the designated teacher for child protection, who should inform social services.

CO-OPERATION WITH SOCIAL SERVICES

3.47 The education service itself **does not have an investigative responsibility** in child protection work. However, schools and Education Welfare staff have a role in assisting social services by referring concerns and providing information which will contribute to child protection investigations. Social services may on occasions ask staff working in education for information about a child where there are concerns about abuse or neglect.

3.48 Where a child of school age is the subject of an inter-agency child protection plan, the school should be involved in its preparation. The plan should clearly indicate the school's role and responsibilities in helping to safeguard the child. Where the school has not been involved in the development of the plan, they should be made aware in writing that a plan is in place.

DUTIES OF EDUCATION SERVICE

3.49 Throughout the education service:

- a senior officer should be appointed in each Education & Library Board, the Council for Catholic Maintained Schools, Northern Ireland Council for Integrated Education and in Irish Medium Schools to take responsibility for co-ordinating action on child protection issues;

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- school governors should ensure that their school has a child p rotection policy and procedures based on the guidance provided by the edu cation authorities and consistent with ACPC procedures. The policy and procedures should include the action to be taken in cases of bu llying;
- as part of these procedures, each school should have a designated teacher to whom all allegations or suspicions of child abuse should be referred for notification to social services. The designated teacher should receive training in this role;
- the school's procedures should give clear guidance on the acti on to be taken if a member of staff is suspected of abusing a child;
- school governors should be aware of their own direct responsibility to take action in the event of allegations or suspicions of abuse by the principal;
- all staff should be trained to be alert to the signs of possible abuse and know the action to take if they have concerns.

INDEPENDENT SCHOOLS

3.50 The role of independent schools in relation to child protection is the same as that of any other school and similar policies and procedures sh ould be adopted.

YOUTH SERVICE

3.51 Education and Library Boards and youth organisations with regio nal head offices should produce written child protection procedures for their staff, consistent with ACPC and Department of Education guidance. DHSSPS has provided *"Our Duty to Care"* (2000), a good practice guide for voluntary organisations on the principles and practice for the protection of children and young people.

3.52 Senior officers of the Youth Service should be designated to fulfil a role similar to that of the designated teacher. Youth and community workers have frequent contact with children and young people, and should be alert to the signs of possible abuse and neglect. They should know the procedures to be followed, and to whom they should report suspicions or concerns about the child's welfare.

DAY CARE/AFTER-SCHOOL SERVICES

3.53 Staff in children's day care/after-school services may become aware that a child is suffering, or likely to suffer, significant harm. Their employers should have procedures for them to follow, which include how to contact social services in the event of such concerns. Staff should be given child protection training so that they can recognise, at an early stage, the signs and behaviour that give rise to concern. It is important that people working in day care services, or as childminders, are properly supported and are enabled to contribute, where appropriate, to child protection case conferences and plans.

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POLICE

3.54 The police have a duty and responsibility to investigate criminal offences committed against children. The child's welfare is the overriding consideration and investigations should be carried out sensitively, thoroughly and professionally. The police's aim will be to:

- find out whether a crime has been committed;
- identify those responsible; and
- secure the best possible evidence for criminal proceedings.

3.55 In dealing with offences involving a child victim, the police will work in partnership with social services. While the responsibility to instigate criminal proceedings rests with the police, the police should always consider the views expressed by other parties about what is in the child's best interests.

POLICE POWERS IN EMERGENCIES

3.56 The police have emergency powers to enter premises and to ensure the immediate protection of children who are believed to be suffering, or at risk of suffering, significant harm. Such powers should be used only when necessary, the principle being that wherever possible the decision to remove a child from a parent or carer should be made by a court.

CHILD ABUSE AND RAPE ENQUIRY (CARE) UNITS

3.57 The police have a number of Child Abuse and Rape Enquiry (CARE) Units to deal with cases of child abuse and sexual offences. CARE Unit staff should investigate the criminal aspects of child abuse allegations. It is important, therefore, that such units include sufficient staff with investigative experience commensurate with the serious nature of their work.

ROLE OF ALL POLICE

3.58 It is also important that safeguarding children is not, within a policing context, seen as solely the role of CARE Unit officers, but that all police officers understand it is a fundamental part of their duties. Officers attending domestic violence incidents in particular should be aware of the effect of such violence on any children within the household.

POLICE/SOCIAL SERVICES LIAISON

3.59 The police and social services have different functions, powers and methods of working. While the police are concerned with the investigation of alleged offences, the focus of social services work is on the welfare of the child and family. Nevertheless, these functions are complementary and joint investigations and interviewing arrangements by the police and social services have been established under a joint protocol[3].

3 *Protocol for the Joint Investigation, by Social Workers and Police Officers, of Alleged and Suspected Child Abuse*

INFORMATION SHARING

3.60 Police officers should be prepared to share information and intelligence with other agencies, where this is necessary to safeguard children. This includes ensuring that officers at a child protection conference are fully informed about the case as well as being experienced in risk assessment and the decision making process.

3.61 Whether or not it is decided to prosecute, evidence gathered during a criminal investigation may be of use in deciding if a child needs protection and in preparing for civil proceedings to safeguard the child. The Director of Public Prosecutions (DPP) should be consulted, but he will normally allow evidence to be shared, if it is in the best interests of the child.

CRIMINAL PROCEEDINGS

3.62 Although the police may investigate, it is the responsibility of the DPP to decide on and carry out prosecution. In deciding to initiate criminal proceedings consideration should be given to whether or not:

- there is sufficient evidence to prosecute;
- it is in the public interest that proceedings should be instigated; and
- it is in the best interests of the child.

STANDARDS OF PROOF

3.63 Criminal courts require proof beyond reasonable doubt that the defendant committed the offence. The burden of proof rests with the prosecution; defendants do not have to prove their innocence. Proceedings for the protection of children under the Children Order take place in the civil courts which works to a different standard of proof, that of the balance of probabilities. The DPP may decide not to prosecute a person suspected of child abuse because there is insufficient evidence to meet the standard of proof necessary for criminal cases. However, the civil courts may decide that the child needs protection from the same person using the lower standard of proof required in civil cases.

PROBATION SERVICE

3.64 The Probation Board for Northern Ireland (PBNI) has a statutory duty to supervise offenders effectively in order to reduce offending and protect the public. PBNI works within the courts, prisons and in the community. Probation officers provide reports on children and adults to the courts after consultation with a range of other professionals engaged in safeguarding children. Their reports contain information and assessments to assist the court in determining the most appropriate sentence for an offender taking account of the need for public protection and the re-integration of an offender into the community. PBNI also works in partnership with HSS Boards and Trusts and other relevant agencies to provide programmes for individuals whose behaviour presents a risk to children.

3.65 PBNI is also responsible for the community supervision of children and adults who are subject to a range of court orders (custody probation orders, juvenile justice orders, community service orders, combination orders and probation orders). In relation to children (aged 10 –16 years inclusive) supervision is carried out by PBNI's Youth Justice Unit which works in conjunction with the statutory and voluntary sectors. PBNI have agency procedures in place to ensure that safeguards are in place for children who are subject to community supervision orders. If, in the course of their work, probation officers have concerns about a child, PBNI should refer without delay the case to the relevant Trust. This includes cases where the offender is a parent/carer or sibling of the child.

3.66 PBNI is also responsible for the statutory supervision of life sentence prisoners who are released on licence as well as the supervision of those released on sex offender licences. In specific circumstances, PBNI undertakes the supervision of those not currently on licence or subject to a supervision order but who are subject to a multi-agency risk assessment and risk management plan.

3.67 A senior representative of PBNI is involved in the Northern Ireland Sex Offender Strategic Management Committee and designated PBNI Area Managers have responsibility for chairing Area Sex Offender Risk Management Committees.

PRISON SERVICE

3.68 The Northern Ireland Prison Service should have procedures for referring children at risk of significant harm to social services. Governors should ensure that all staff are aware of these procedures.

PRISONERS WHO PRESENT A RISK

3.69 The prison service should work closely with other agencies to identify any prisoner who may pose a risk to children on his release. Under DHSSPS guidance (see circular HSS 3/96) on the supervision of dangerous offenders who are being released from prison, Governors must ensure that social services and the probation service are notified of plans to release prisoners convicted of offences against children so that appropriate action can be taken to minimise any further risk to them.

CHILDREN OF PRISONERS

3.70 The prison service and the probation service recognise the importance for children of being able to maintain contact with a parent in prison and is also committed to helping prisoners maintain their family ties. However, prison staff should be aware of the need to protect children from significant harm, and Governors have the discretion to prohibit any visit to a prisoner by a person under 18 if it would not be in the child's best interest. Similarly, a Governor has discretion to prevent communications between prisoner and child.

CHILDREN IN PRISON

3.71 It is particularly important that, where a mother has the care of her baby in prison, any concerns about her care of the child should be repo rted immediately to social services so that consideration can be given to how best to safeguard the child and promote his welfare.

CHILDREN IN CUSTODY

3.72 Children are held in custody in prisons and juvenile justice ce ntres. The managers of these services have a duty to protect and promote the welfare of children in their custody.

3.73 When a child in custody complains of abuse by either staf f of the institution or anyone else, it is essential that child protection procedure s are followed. Social services should be informed immediately so a full investigation may be conducted.

SEX OFFENDERS

3.74 In any case where an of fender is considered to pose a risk to c hildren, social services in the area where he lives (or intends to live in the case of prisoners) should be alerted. All agencies working with sex of fenders including the probation service, the prison service, the police and social se rvices should assess the risk posed to children by sex of fenders. The Sex Of fender Act (1997) requires certain sex of fenders to register with the police. Multi-agency case conferences should be convened to assess and manage the risk posed by them. Guidance on the inter-agency management of sex of fenders is contained in *"Multi-Agency Procedures for the Assessment and Management of Sex Offenders"(1999)* produced by the NIO.

THE VOLUNTARY AND COMMUNITY SECTOR

3.75 Voluntary organisations play an important role in the provision of children' s services. Trusts should be alert to the opportunities to promote voluntary effort in their areas to combat child abuse and should designate an appropriate member of staff to provide advice to the voluntary sector on child protection matters.

3.76 In broad terms, the voluntary and community sectors' roles fall within the following areas:

- help lines;
- provision of direct services;
- public education/campaigning.

3.77 It is essential that all such organisations have child protecti on policies and procedures and that their staff and volunteers should receive training in their use. DHSSPS has provided *"Our Duty to Care"*, a good practice guide for voluntary organisations on the principles and practices for the safeguarding and protection of children.

NSPCC

3.78 The NSPCC is a voluntary organisation with a particular responsibility for child protection. Its Royal Charter places upon it "the duty to ensure an appropriate and speedy response in all cases where children are alleged to be at risk of abuse or neglect in any form". Uniquely amongst voluntary bodies, the NSPCC has a power to bring care proceedings in its own right under Articles 49 and 50 of the Children Order. NSPCC staff have a responsibility to identify and prevent cruelty to children.

3.79 The Society has created, in co-operation with some Trusts, child protection teams and projects to provide specialist services. Such collaboration is essential if the best use is to be made of the Society's expertise in child protection work. The NSPCC contributes to training, particularly multi-disciplinary training.

HOUSING AGENCIES

3.80 The Northern Ireland Housing Executive and housing associations can play an important role in safeguarding children through recognition, referral and the subsequent management of risk. Their staff, through their day-to-day contact with members of the public may become aware of concerns about the welfare of particular children and should immediately inform social services about these concerns.

3.81 Housing agencies may have important information about families that could be helpful to Trusts carrying out assessments of children at risk. In accordance with their duty to assist under Articles 46 & 66 of the Children Order, they should be prepared to share relevant information verbally or in writing, including attending child protection case conferences when invited.

3.82 On occasions, housing agencies can make an important contribution to safeguarding children by the provision of accommodation. Examples could include situations where women and their children have become homeless or at risk of homelessness as a result of violence in the family. Housing agencies also have an important part to play in the management of the risk posed by dangerous offenders, including those who are assessed as presenting a risk, whether sexual or otherwise, to children. Appropriate housing can contribute greatly to the ability of the police and others to manage the risk such individuals pose.

THE NORTHERN IRELAND GUARDIAN AD LITEM AGENCY

3.83 The Guardian ad Litem (GAL) is an independent person appointed by the court in nearly all public law cases under the Children Order to represent the child's interests in court proceedings. This role is likely to bring them into contact with families where children are at risk of significant harm. The Northern Ireland Guardian ad Litem Agency (NIGALA) should ensure that it has appropriate child protection policies and procedures and that all staff and GALs have training in their use.

3.84 Many of the public law proceedings which involve GALs will stem from allegations of child abuse. The responsibility of GALs dif fer from those of other professionals working with children in that information o btained by them in the course of their duties is privileged. With the permission of the court information may be disclosed. NIGALA should ensure that it has child protection policies and procedures and that GALs are aware of the action they should take if they have reason to believe that a child is at risk of significant harm.

THE WIDER COMMUNITY

3.85 All of the agencies mentioned in the paragraphs above can do much to promote a better understanding of their work and to develop a p artnership with the wider community by raising public awareness of their work. They should also provide information and advice on:

- the services local agencies provide for children in need and their families;
- how and when to make contact where there are concerns about a child;
- the response that members of the public and service users should expect from them.

Professionals and agencies should be aware of the role that the community , religious and voluntary groups can play in safeguarding childre n. It is important that all community organisations establish and mainta in child protection procedures in keeping with local ACPC guidance. They should also ensure that staff know who in social services to contact in the event of requiring advice or to notify concerns.

3.86 The community also possesses strengths and skills that can be harnessed for the benefit of vulnerable children and their families, includin g children at risk of significant harm. Community resources might include self-hel p and mutual aid initiatives, information resources and networks, support se rvices, and advocacy and campaigning initiatives.

LOCAL GOVERNMENT

3.87 Local councils in Northern Ireland carry out a range of functions and services through community centres, leisure centres and other community schemes that directly and indirectly involve children.

3.88 Staff employed by local councils and those contracted for work with children may become involved in child protection cases either because of suspicions or allegations in respect of their own conduct with children or be cause, during their duties, they become aware of the possibility of abuse having been perpetrated by others.

3.89 It is essential that local councils should have clear policies and procedures for dealing with such circumstances. ACPCs should encourage them to develop appropriate links with their local HSS Trust.

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THE ARMED SERVICES

3.90 The life of a Service family differs in many respects from that of a family in civilian life. The employing service, specifically the commanding officer, is responsible for the welfare of Service families.

3.91 The frequency of moves, due to Services commitments makes it essential that the Service authorities are fully aware of any child for whom there are child protection concerns. The Armed Forces are fully committed to co-operation with statutory and other agencies in supporting families in this situation, and have in place procedures to help in safeguarding children.

3.92 Trusts have the statutory responsibility for the protection of the children of Service families based in Northern Ireland. However, all three Services - Army, Navy and Airforce - provide professional welfare support including social work services and, in some cases, medical services to augment those provided by Trusts. In the Royal Navy this is provided by the Naval Personal and Family Service (NPFS) and the Royal Marines Welfare Service. Within the Army this is provided by the Army Welfare Service in partnership with the Soldiers', Sailors' and Airmens' Families Association (SSAFA-Forces Help) and in the Royal Air Force by SSAFA Forces Help. In Northern Ireland welfare of families of all three services is monitored by the Personal Welfare Service, co-ordinated by SSAFA Forces Help. Further details of these services and contact numbers are given at Appendix 1.

3.93 When Service families (or civilians working with the Armed Forces) are based overseas, the responsibility for the protection of their children is vested with the Ministry of Defence (MoD). The military authorities work in conjunction with the specialist authorities, particularly SSAFA-FH, who provide a fully qualified social work and community health service in major overseas locations (e.g.Germany and Cyprus). Instructions for the protection of children overseas, which reflect the principles of the Children Act (1989) and the philosophy of inter-agency co-operation, are issued by the MoD as a *"Defence Council Instruction (Joint Service)"* (DCI JS). Larger overseas Commands issue local child protection procedures, hold a Command Child Protection Register and have a Command Child Protection Committee which operates in a similar way to ACPCs in the United Kingdom in upholding standards and making sure that best practice is reflected in procedures and observed in practice.

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Area Child Protection Committees and Child Protection Panels

4

INTRODUCTION

4.1 Although social services staff in Boards and Trusts have responsibility for child protection services, a multi-disciplinary approach to this work is essential. As a result there should be an Area Child Protection Committee (ACPC) in each Board area to determine the strategy for safeguarding children and to develop and disseminate policies and procedures. In each community based Trust there should be a Child Protection Panel to facilitate practice at a local level. A Child Protection Panel in a hospital Trust can be helpful particularly where their work brings them into front-line contact with children and involves the assessment and treatment of children, some of whom may be at risk of significant harm. Consideration should be given to establishing a Child Protection Panel in hospital Trusts or as a minimum ensuring that there is a senior hospital representative included in the community panel who can ensure that hospital and community links are properly managed and hospital-related child protection issues are addressed.

AREA CHILD PROTECTION COMMITTEE (ACPC)

ROLE AND RESPONSIBILITIES

4.2 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:

- to develop, agree and review policies and procedures for inter-agency work to protect children, within the framework provided by this guidance;
- to improve outcomes for children by setting objectives, performance indicators and establishing appropriate thresholds for intervention taking account of the multi-professional/agency contribution to child protection;
- to ensure that equality of opportunity is central to the development of child protection policies and procedures and to guarantee that an equality perspective is incorporated in child protection policy at all levels and all stages;
- to put in place and implement a strategy, in conjunction with CPPs, for developing effective working relationships between services, professional and community groups with the aim of safeguarding and promoting the welfare of children who are at risk of significant harm;
- to communicate clearly to individual services and professional groups their shared responsibility for protecting children, and to explain how that responsibility can be fulfilled;
- to bring to the attention of board members within HSS Boards and Trusts their responsibilities for child protection issues and developments in the area and how the ACPC Business Plan will address these;
- 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 are conveyed to Boards, Trusts, constituent agencies of ACPC and professional groups;

- to develop an inter-agency/inter-disciplinary training and development strategy with the aim of improving the quality of child protection work and of inter-agency/inter-disciplinary working having identified the training needs of those involved in child protection work in the area. The strategy should take account of how training partnerships with CPPs can be developed;
- to ensure that there is a link between ACPCs and the Northern Ireland Sex Offender Strategic Management Committee;
- to develop a public communication strategy, and ensure its implementation in conjunction with CPPs, to raise awareness within the wider community of the need to safeguard children and to highlight the contribution that communities can make;
- to develop an information strategy aimed at children and families to enable them to understand child protection processes, particularly those involved in them;
- to undertake Case Management Reviews in accordance with Chapter 10 of this guidance and to make sure that the lessons learned are clearly communicated, understood, and actioned, that the review outcomes inform practice and that there is a process in place to measure practice improvements;
- to continually review local ways of working, taking account of knowledge gained through research and national and local experience to bring about child protection service improvements through the children's service planning process;
- to work collaboratively with other ACPCs, where appropriate.

ACCOUNTABILITY

4.3 The ACPC and its Chair are accountable to the HSS Board which constituted the committee. ACPC members are also, however, accountable to the agencies that they represent which, in turn, are responsible for taking any action properly falling within their respective remits. The ACPC must work to agreed written terms of reference which set out its remit and the level of decision-making which can be agreed by agencies' representatives without referral back to individual member agencies. Each agency must accept that it is responsible for assessing the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their agency for the safeguarding of children are given proper consideration. Contributing agencies are expected to have a mechanism for considering the policy, planning and resource implications of issues brought to the attention of the agency by its ACPC representative.

4.4 As the body with lead responsibility for children's services planning, each HSS Board should take lead responsibility for the establishment and effective working of ACPCs. However, all main constituent agencies are responsible for contributing fully and effectively to the work of the ACPC.

ACPCs AND CHILDREN'S SERVICES PLANNING

4.5 Each Board is required to have a Children and Young People's Committee and to produce a Children's Services Plan that brings together all aspects of services for children in the Board area. Plans should look widely at the needs of all children in the area, and the ways in which local services (including statutory and voluntary services) work together to meet those needs. They should include specific priorities and proposals for improving children's services, details of what action will be taken and by whom, and how the outcome will be monitored (see *Children's Services Planning – Guidance* (July 1998).

4.6 ACPCs should contribute to, and work within the framework of the Children's Services Planning process. Within the children's services planning framework, different agencies will also work together in different forums to plan co-ordinated action. Examples include early years development, substance misuse, domestic violence, and improving children's health and well-being. The Children's Services Plan will need to make links between these related activities. Guided by the plan, the ACPC will need to be aware of, and to contribute to, the work of others, and vice-versa.

ACPC MEMBERSHIP

4.7 ACPCs should be made up of members from the main statutory and voluntary agencies involved in child protection work in the Board's area. In some areas ACPC members may carry a dual role e.g. they may chair a Child Protection Panel and represent a professional group. Contributing to the work of the ACPC is an important responsibility for local agencies. Each agency should ensure active participation and representation at a sufficiently senior level so that the ACPC can effectively influence the development of local policy and practice in child protection. Representatives should attend regularly to ensure continuity from all local interests. This includes membership of sub-committees or working groups. Membership of ACPC should be drawn from senior staff with responsibility for policy development and implementation ***representing:***

- relevant professional groups from the HSS Board;
- relevant professional groups from the HSS Trusts;
- Child Protection Panels;
- General Practitioner from the area;
- Education and Library Boards;
- Council for Catholic Maintained Schools;
- PSNI;
- PBNI;
- Juvenile Justice Agency;
- NSPCC;

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- the Co-ordinator or Senior Social Work Practitioner, SSAFA Forces Help Social Work Services where there is a large service base in the area.

The ACPC should make appropriate arrangements to involve other agencies and professionals in its work as necessary and the ACPC's annual business plan (see paragraph 4.15) should provide information on the contribution to the business of the ACPC.

WORKING GROUPS

4.8 ACPCs should consider setting up working groups to:

- carry out specific tasks (e.g. maintaining and updating guidance and procedures; identifying inter-agency training needs and arranging appropriate training); and
- provide specialist advice (e.g. working with specific ethnic or cultural groups, or with disabled children and/or parents); and
- carry out audits, in conjunction with Child Protection Panels, to look at inter-agency safeguarding arrangements, identify good practice and highlight areas for improvement.

4.9 All groups working under the auspices of the ACPC should have been established by the ACPC, and should work to agreed terms of reference within the framework of the annual business plan, and with explicit lines of communication and accountability to the ACPC.

CHAIR AND SECRETARIAT

4.10 It is essential that the Chair of the ACPC has a firm grasp of local operational issues and is of sufficient standing and expertise to command the support and respect of all member agencies. The Chair may come from any member agency, be independent or member agencies may agree to rotate chairing between them. The appointment and method of appointment must take account of the HSS Board's accountability arrangements and are matters for local agreement.

4.11 HSS Boards are responsible for providing ACPCs with a secretariat and other support services.

FINANCING AND ADMINISTRATION

4.12 ACPC expenditure, and administrative and policy support, is a matter for local agreement. As a multi-agency forum, the ACPC should be supported in its work by all its constituent agencies, reflecting the investment of each agency in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities.

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CO-OPERATION BETWEEN ACPCs

4.13 ACPCs should actively seek to co-operate with each other to avo id unnecessary duplication of work, to promote consistency in both practice and information gathering and to draw on individual strengths of AC PCs. Some issues that would benefit from such co-operation are:

- producing and reviewing policies and procedures;
- developing training programmes and organising training events; and
- sharing of information and concerns that af fect all Boards and Trusts.

ACPC PROCEDURES

4.14 ACPCs should have in place procedures covering:

- the management of a case from referral and through each stage of the process;
- the protection of children in groups known to be vulnerable an d in specific circumstances (see appendix 4).
- how child protection enquiries and associated police investiga tions should be conducted, and in particular, in what circumstances joint en quiries are necessary and/or appropriate (see paragraph 3.59);
- the arrangements to enable the police to make referrals to social services when child protection concerns emerge during the course of an investigation into abuse by strangers (see paragraphs 6.2 – 6.3);
- the roles and responsibilities of particular disciplines and s taff within agencies working to safeguard children;
- a quick and straightforward means of resolving professional dif ferences of view in a specific case, for example, on whether a child protection case conference should be convened;
- attendance at child protection case conferences;
- the involvement of children and family members in child protection case conferences, the role of advocates as well as criteria for excl uding parents/carers in exceptional circumstances;
- decision-making processes for registration which take account of the views of the agencies present at the child protection case conference ;
- the handling of complaints from families about the functioning of child protection case conferences.

ANNUAL BUSINESS PLANS

4.15 Each ACPC should produce an annual business plan. The plan shou ld set out a work programme for the forthcoming year and include measurable objectives. It should include statements of progress against objectives for the

previous year. Relevant management information on child protection activity in the course of the previous year should also be included. ACPCs' plans should both contribute to, and derive from the framework of the local children's services plans and should be endorsed by senior managers in each of the main constituent agencies.

4.16 ACPCs may wish to make the business plan, or an edited version of it, available to a wider audience, for example to explain to the wi der community the work of local agencies in helping to safeguard ch ildren.

4.17 Constituent agencies should provide the ACPC with management in formation on the level of activity and trends in child protection work within their agency on an annual basis. It should not include identifying d etails of individuals.

TRUST CHILD PROTECTION PANEL (CPP)

ROLE AND RESPONSIBILITIES

4.18 The role of the CPP in community Trusts is to implement locally the ACPC's policy and procedures ensuring a high standard of professional practice. Its main tasks are:

- to work within, and contribute to the ACPC business plan and u ltimately Children's Services Plans;
- to implement the ACPC's child protection policies and procedur es;
- in partnership with ACPC to measure how and to what degree the objectives and performance indicators set by ACPC have improved outcomes for children in the locality;
- to monitor and evaluate how well local services work together to protect children. This should be done in partnership with ACPC and form part of the ACPC annual business plan;
- to encourage and develop good working relationships between di fferent services, professional and community groups with the aim of dev eloping trust and mutual understanding;
- to co-operate with relevant agencies in implementing the *"Multi-agency Procedures for the Assessment and Management of Sex Of fenders (MASRAM)"*;
- to advise the ACPC and CPP's constituent agencies on resource needs;
- to contribute to the ACPC training and development strategy an d to the delivery of training and development programmes on a multi-agency/disciplinary basis and, in partnership with ACPC, to ass ess how identified training/development needs are being met;

- to promote public awareness about child protection services in co-ordination with other CPPs and in keeping with the ACPC public communication strategy; and

- to provide an annual report to the ACPC.

Given the particular roles and responsibilities of acute hospital Trusts, child protection panels in those Trusts should fulfil the tasks which are appropriate to them. They will also need to establish a liaison mechanism with community CPPs.

ACCOUNTABILITY

4.19 The CPP as a body is accountable to the Trust, although its members are accountable to the agencies they represent. The CPP should work within the agreed ACPC Business Plan and child protection policies and procedures, which they do not have the discretion to amend. Each agency should accept that it is responsible for monitoring the performance of its own representative. Each agency is expected to have procedures in place for considering reports from its CPP representative and the implication for policy, planning and resources.

TERMS OF REFERENCE

4.20 The CPP should work within agreed terms of reference that set out its remit. The terms of reference should include the level of decision-making that may be agreed by agency representatives, without referral back to individual member agencies.

CPP MEMBERSHIP

4.21 The CPP should be made up of members from the main statutory and voluntary agencies involved in child protection work in the Trust's area. The membership of the Trust's CPP should include practitioners and managers from a range of disciplines and agencies including:

- HSS Trusts;

- Education and Library Boards/Schools;

- Council for Catholic Maintained Schools/Schools;

- Local General Practitioner;

- PSNI;

- PBNI;

- Juvenile Justice Agency;

- NSPCC;

- the Co-ordinator or Senior Social Work Practitioner, SSAFA Forces Help Social Work Services where there is a large service base in the area.

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In relation to HSS Trusts, consideration should be given to including a representative of the domestic violence forum and those with expertise from a variety of relevant medical specialities including paediatrics, accident & emergency departments, forensic medicine, mental health and allied health professionals. Consideration should also be given to including community and voluntary representatives providing services in the area. In relation to hospital Trusts, membership should be drawn from the range of disciplines who have contact with children.

CHAIRING

4.22 A community CPP should be chaired by the Trust's Director of Social Work or a senior designated nominee. In relation to hospital Trusts, the CPP should be chaired by a senior member of medical or nursing staff.

FINANCE AND ADMINISTRATION

4.23 The Trust is responsible for core funding the CPP and providing it with a secretariat and other support services. As a multi-agency forum, the CPP should be supported in its work by all its constituent agencies, reflecting the investment of each agency in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities.

INFORMATION FOR THE CPP

4.24 Constituent agencies should provide the CPP with management information on the level of activity and trends in child protection. It should not include information capable of identifying any individual.

INFORMATION FROM THE CPP

4.25 The CPP should review annually the child protection work in its area and plan for the year ahead. This information should be submitted to the Trust Board, copied to the ACPC and circulated to all constituent agencies as soon as possible after the end of the financial year.

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Handling Individual Cases

5

INTRODUCTION

5.1 This chapter provides advice on what should happen where there are concerns that a child is suffering, or is likely to suffer, significant harm. It is not intended to constitute procedural guidance, which should be devised by the ACPC. It sets out, however, the Department's expectations about the ways in which agencies and professionals should work together in the interests of safeguarding children. ***At all stages*** there must be a record maintained of all discussions, decisions and actions taken, including actions by other agencies and these must be placed on the child's file. There must also be written and signed endorsement and review by a line-manager at each stage of the process.

CO-OPERATION BETWEEN AGENCIES

5.2 The Children Order places a statutory duty on health, education and other services, to help social services with their enquiries. The ACPC and CPP have an important role to play in cultivating and promoting a climate of trust and understanding between different professionals and services to facilitate the discharge of this duty.

WORKING WITH THE FAMILY

5.3 Family members have a unique role and importance in the lives of children, and children attach great value to their family relationships. Family members know more about their family than any professional could possibly know, and decisions about a child should draw upon this knowledge and understanding. Family members have the right to know what is being said about them, and it is crucial that they are helped to contribute in a variety of ways to important decisions about their lives and those of their children. Research findings brought together in *Child Protection: Messages from Research (1995)* endorse the importance of good relationships between professionals and families in helping to bring about the best possible outcomes for children. Where there is compulsory intervention in family life, parents should still be helped and encouraged to play as large a part as possible in decisions about their child. All family members should be treated with courtesy, dignity and respect.

5.4 Partnership does not mean always agreeing with parents or other adult family members, or always seeking a way forward which is acceptable to them. The aim of child protection processes is to ensure the safety and welfare of a child, and the child's interests must always be paramount. Some parents may feel hurt and angry and refuse to co-operate with professionals. Not all parents may be able to safeguard their children, even with help and support. Especially in child sexual abuse, some may be vulnerable to manipulation by a perpetrator of abuse. A minority of parents may be actively dangerous to their children, other family members, or professionals, and unwilling and/or unable to change. Professionals should always maintain a focus on the child and what is best for him.

RACE, ETHNICITY AND CULTURE

5.5 To make sensitive and informed judgements it is important that professionals are aware of differing family patterns, lifestyles and child rearing practices across different racial and cultural groups. However, professionals should guard against myths and stereotypes, both positive and negative, of ethnic minority families. Anxiety about being accused of racist practice should not prevent the necessary action being taken to safeguard a child. Cultural factors neither explain, nor condone acts of commission or omission that put a child at risk of significant harm.

INVOLVING CHILDREN

5.6 Children often have a clear perception of what needs to be done to ensure their safety. However, most of them feel loyalty towards those who care for them, and have difficulty disclosing information which may be harmful to their family. Many do not wish to share confidences, or may not have the language or concepts to describe what has happened to them. Some may fear reprisals, or their removal from home. Children need to feel safe before they disclose information which they believe will produce negat ive consequences for themselves or others.

5.7 Children and young people need to understand the extent and nat ure of their involvement in decision-making and planning processes and need careful preparation and support throughout the process. They sh ould be helped to understand:

- how the child protection process works;
- how they can be involved; and
- how their views will be taken into account when decisions abou t their future are being made.

5.8 They should understand that ultimately, decisions will be taken in the light of all the available information contributed by professionals, themselves, their parents and other family members, and other significant adults. In recent years, Family Group Conferences have proved ef fective in a number of areas as a means of resolving family problems. Serious consideration should be given to their use as part of the process of safeguarding child ren.

SUPPORT TO CHILDREN AND FAMILIES

5.9 Where children and families are involved as witnesses in court proceedings, consideration should be given to what can be done to make it less daunting. The whole process should be explained in advance to reduce anxi eties. Children, in particular, need preparation and support for court appearances. The NSPCC has a scheme to provide support and has produced *The Young Witness Pack(1998)* to provide information and advice to children and parents who will give evidence in court.

BEING ALERT TO CHILDREN'S WELFARE

5.10 Everybody who works with children should be able to recognise, and know how to act upon, concerns that a child may be at risk. They should know:

- when and how to make a referral to social services;
- that emergency action should never be delayed, if it is needed to safeguard a child;
- that a written record should be kept of any concerns they have about a child considered to be at risk and the investigation conducted; that details of further action taken should also be recorded and the basis for a decision not to act further should be recorded and countersigne d by a senior officer of the agency; and
- that a written record should be kept of discussions within the ir own agency or with others about a child's welfare.

REFERRALS TO SOCIAL SERVICES

5.11 Although Trusts, the police and the NSPCC have the power to investigate and intervene when a child is suffering, or may be at risk of suffering, significant harm, referrals should normally be made to social services. There may, however, be occasions when a referral to one of the other agencies would be more appropriate.

TAKING THE REFERRAL

5.12 When someone refers a concern about a child to social services the person whose duty it is to take the referral should know the processes to be followed, particularly in relation to the need to take urgent action on receipt of the referral information. Where the referral information reveals or suggests deliberate harm to a child then the child must be seen and spoken to within 24 hours of the referral being communicated to social services. The person taking the referral should have the competence to enable him to:

- assess whether the nature of the concern indicates the possibility of significant harm;
- assess whether urgent action is needed to safeguard the child;
- establish how the concern has arisen; and
- assess what other needs the child and family may have at this initial stage.

SOCIAL WORKERS IN HOSPITALS

5.13 Where suspicions of deliberate harm are conveyed to social workers in a hospital setting they, too, must always respond promptly and follow ACPC procedures and guidance. They must see and talk to the child, to the child's carer and to the other disciplines responsible for the care of the child in hospital. They must also contact their social work colleagues i n child protection in community social services so that the case can be progressed in

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accordance with agreed procedures. Hospital social workers have a responsibility to ensure that, where there are child protection concerns, the child is not discharged until it has been established that the home environment is safe, the concerns of medical and other hospital staff have been fully addressed and there is a plan in place for the ongoing promotion and safeguarding of the child's welfare. Hospital social workers should also participate in all hospital meetings concerning the safeguarding of children.

CONFIRMING REFERRALS IN WRITING

5.14 Professionals who make verbal, or telephone, referrals to social services should confirm them in writing within 24 hours. At the end of any discussion about a child, the referrer and the person taking the referral within social services should be clear about:

- who will be taking what action, or that no further action will be taken;
- the requirement to record the decisions/actions taken by the receiver of the referral. Recording should take place in the child's case file;
- the requirement to confirm receipt of the referral to the referrer in writing and the actions agreed.

Receipt of a referral from a member of the public should also be acknowledged in writing by the person taking the referral. A manager should read, agree the decisions/actions recorded and countersign and date the child's case file.

JOINT ACTION BY THE POLICE AND SOCIAL SERVICES

5.15 When a case that may constitute a crime against a child is referred to social services, it should be forwarded immediately to the police. This may include referrals relating to events which happened in the past. A manager from both agencies should jointly consider how to proceed in the best interests of the child or children who may be affected. In cases of abuse within the family, or by other carers, the police should normally work in partnership with social services under the *Joint Protocol* (see paragraph 3.59). However, there may be cases where, after discussion, it is agreed that social services should take the lead role in investigating the concerns. On the other hand, there may be cases, such as allegations of abuse by strangers or those alleged to have happened in the past, where a police investigation of the criminal aspects of the case may need to be the first stage in the process.

STRATEGY DISCUSSION

5.16 A strategy discussion may take place at a meeting or by other means e.g. by telephone. After checking any existing records and following discussion with the referring agent and other professionals the social services and police managers should during their strategy discussion consider and decide:

- whether the information obtained indicates the need for immediate protective action;
- what action, if any, will be taken within 24 hours.

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5.17 The strategy discussion should also be used to:

- determine the need to obtain additional information about the child and family from other agencies or professionals;
- decide whether child protection enquiries should be initiated, what this will include, when this will take place and who will be respons ible for subsequent planned action;
- consider the need for a medical examination and/or other medic al treatment;
- determine what information will be shared with the family;
- consider the needs of other children and if they have been af fected; and
- determine how legal advice, where necessary, will be accessed.

5.18 Significant harm to children often gives rise to both child pro tection and law enforcement concerns. Child protection enquiries may run concur rently with police investigations and provide information that is relevant to decisions that have to be taken by both social services and the police. Good communication between both agencies is, therefore, essential.

5.19 Where further action has been agreed **the social work manager must:**

- plan with the social worker (to whom the case has been allocat ed) how child protection enquiries will be handled taking account of th e information obtained through the referral and as a result of re cord checking and information obtained from other agencies and profe ssionals.
- agree a contingency plan with the social worker (to whom the case has been allocated);
- agree the process for managing, supervising and reviewing the outcome of enquiries made;

INITIAL ASSESSMENT FOLLOWING REFERRAL AND ALLOCATION

5.20 **The initial assessment following referral to determine the needs of and risks to the child should be completed within a maximum of seven working days from the date of referral using the procedures developed by the Trust** (see paragraph 1.10). In cases where the assessment reveals that there is an immediate risk to the child, it will be necessary to take emergency action to protect the child.

INITIAL PLAN

5.21 An initial plan should be developed which sets out the actions to be taken and support mechanisms which can be put in place immediately to manage the risks to the child identified at this point.

5.22 Following the initial assessment, social services or where appropriate, the NSPCC should:

- analyse the additional information obtained;
- decide on any further action required;
- make sure that the decisions taken up until this point and initial plan are endorsed at a senior level within social services and recorded immediately on the child's case file; and
- inform agencies and professionals involved in the referral and assessment processes what action is to be taken. The family should also be informed, provided this will not jeopardise further action to safeguard the child or the conduct of a criminal investigation.

Where, during the course of an assessment, social services establish that a child of school age has not ever or is not attending school, they must alert the Education and Library Board for the area and be satisfied that there are adequate day care arrangements in place which safeguard the child.

SECOND STAGE OF ASSESSMENT

5.23 The second stage of assessment, where necessary, should be completed within **15 working days** from the date of referral. A second stage assessment will not be necessary if the initial assessment has concluded that there is not a risk to the child and no further action is needed, or that the provision of services will appropriately meet identified needs of the child. If the second stage assessment rules out that significant harm has occurred, or is likely to occur, the assessment may show that the child is in need as defined by Article 17 of the Children Order. In these circumstances, the Trust's in need assessment procedure should provide a framework for a fuller assessment of the child's needs and the parents' capacity to respond to them.

5.24 Where the assessment gives reason to believe that significant harm may have occurred, or is likely to occur, social services should determine what immediate action is necessary to safeguard the child. In some cases a further strategy discussion may be necessary at this stage to plan the way ahead. In most cases it will be necessary to proceed to an initial case conference at this stage.

IMMEDIATE PROTECTION

5.25 Where there is a serious risk of immediate harm, social services or where appropriate, the NSPCC or the police should act promptly to protect the child. Emergency action may be necessary at any point during the involvement with children and their family. Serious neglect can also pose such a risk of harm making urgent protective action necessary. When considering whether emergency action is necessary, legal advice should be sought and consideration should also be given to whether action is required to safeguard other children in the child's household, or the household of the alleged perpetrator. Where immediate protective action has been taken without legal advice the reasons for this should be recorded on the child's case file.

5.26 Planned emergency action will normally take place following a strategy discussion between police, social services, and other agencies as appropriate. Where social services or where appropriate, the NSPCC or the police have to act immediately to protect a child, a strategy discussion should take place as soon as possible after such action to plan the next steps in safeguarding the child.

5.27 In some cases, it may be sufficient to secure a child's safety by a parent taking action to remove an alleged perpetrator, or the alleged perpetrator agreeing to leave the home. If such an arrangement cannot be achieved voluntarily, an exclusion order can be sought under the Family Homes and Domestic Violence (Northern Ireland) Order (1998), requiring a perpetrator to leave the home instead of having to remove the child. In other cases, it may be necessary to ensure either that the child remains in a safe place, e.g. a hospital, or is removed to a safe place, either on a voluntary basis or by social services obtaining an emergency protection order under Article 63 of the Children Order. In deciding whether to remove a child in an emergency on a voluntary basis, social services should consider what, if any, parental responsibility it requires to safeguard the child. Under Article 65 the police also have powers to remove a child in an emergency. However, it is likely that these powers would only be used in exceptional circumstances.

5.28 Responsibility for emergency action rests with social services in the Trust area where a child is found. If the child's name is on the Child Protection Register or is looked after by another Trust (the responsible Trust); the Trust in the area where the child is found should involve the responsible Trust. However, all Trusts must ensure that there is no delay in taking appropriate emergency action.

CHILD PROTECTION ENQUIRIES

5.29 Most cases of abuse of children involve both criminal and child protection elements. The *'Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse' (Joint Protocol)* allows for investigations by both police officers and social workers. However, it should be borne in mind that the two agencies have different objectives. The aim of the police is to establish whether a crime has been committed and to collect evidence with a view to prosecution. The objective of social services is to safeguard the child, including consideration of the need for care proceedings to achieve this goal. In some cases, particularly of abuse by strangers, it may be appropriate for the investigation to be undertaken solely by the police. In others it may be decided that the criminal aspects do not justify investigation or are unlikely to secure a prosecution and that the investigation should be left to social services. The strategy discussion should include consideration of the need for a Joint Protocol investigation (see paragraph 3.59), or whether one agency should take the lead.

IMPACT OF ENQUIRIES ON THE FAMILY AND CHILD

5.30 Enquiries should always be carried out in such a way as to minimise distress to the child, and to treat families sensitively and with respect. Investigating agencies should explain the purpose, process and potential outcomes of enquiries to parents and, where appropriate, to the child both verbally and in writing. They should answer questions openly and honestly.

5.31 In the majority of cases, even if concerns about abuse or neglect are substantiated, children remain with, or return to, their families during and following enquiries. As far as possible, enquiries should be conducted in a way that allows for future constructive working relationships.

INTERVIEWS AND ENQUIRIES

5.32 Assessing the needs of a child and the capacity of his parents or wider family network to ensure his safety should involve building a comprehensive picture of the family. Enquiries should always involve:

- separate interviews with the child, where his age and stage of development makes this appropriate;
- interviews with parents;
- observation of the interactions between parents and child, where possible;
- interviews with anyone significantly involved in the family, either personally or professionally; and
- acquiring information on any assessment of the child carried out by other relevant professionals.

5.33 It may be necessary to make special arrangements to enable individuals to participate fully in the enquiry. For example, where a child or parent speaks a language other than that used by the interviewer, there should always be an interpreter. If the child, or parent, is unable to take part in an interview because of age (in the child's case), understanding or disability, alternative means of communication should be used. If the services of an interpreter are not used the reasons for this must be recorded in the child's case file.

INTERVIEWING CHILDREN

5.34 Children are often an important source of information about what has happened to them. It is important that even initial discussions with children are conducted in a way that maximises the likelihood of them providing accurate and complete information. The views and wishes of the child expressed during interview should always be recorded on the child's case file. Where possible, children should be interviewed on their own. Leading questions should always be avoided both to ensure that accurate information is obtained and to avoid contaminating evidence possibly required in court proceedings. Children may need time, and more than one opportunity, to develop sufficient trust to be open about what has happened to them. (The Children's Evidence (Northern Ireland) Order (1995) gives judges power to allow children, in certain circumstances, to give their evidence in chief by means of a pre-recorded video. See the *Memorandum of Good Practice* for further information - paragraph 5.37).

5.35 Wherever possible and where necessary the parents' consent to the child being interviewed should be sought and their presence during the interview should be considered. However, a child should never be interviewed in the presence of a suspected perpetrator, or a parent who may have colluded with his abuse. In these circumstances, consideration should be given to involving another relative, friend or someone else the child trusts, to provide support during the interview. These issues should be resolved during the strategy discussion.

5.36 All interviews with children should be conducted by those with specialist training. It may be necessary to involve other people in the interview to take into account special factors, including a child's disability or racial, religious or cultural background. Consideration should also be given to the gender of the interviewers, particularly in cases of sexual abuse.

MEMORANDUM OF GOOD PRACTICE ON VIDEO RECORDED INTERVIEWS WITH CHILD WITNESSES FOR CRIMINAL PROCEEDINGS

5.37 The Northern Ireland Office *"Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings"* covers technical, welfare and legal issues. Agencies should recognise the value of video recorded evidence in both criminal and civil proceedings. ACPC procedures should give guidance on their use taking into account the *Memorandum of Good Practice.*

CHILD ASSESSMENT ORDERS

5.38 The Trust should encourage parents to co-operate with Article 66 enquiries. However, if the parents refuse access to the child, or do not give consent for an interview, the Trust may apply to the court for a child assessment order if the circumstances do not merit an application for an emergency protection order. The court may direct the parents to co-operate with an assessment of the child, the details of which should be specified. The child assessment order lasts for a maximum of seven days from a stated date and the assessment during that period should secure enough information to decide what further action, if any, is necessary. The order does not take away the child's own right to refuse to participate in an assessment, e.g. a medical examination, so long as he is of sufficient age and understanding.

OUTCOME OF ENQUIRIES

5.39 Following enquiries social services should decide how to proceed. This may result in a number of outcomes.

CHILD HAS NOT SUFFERED SIGNIFICANT HARM

5.40 Enquiries may not substantiate the original concerns about the child being at risk of, or suffering, significant harm. In these circumstances, no further action may be needed under child protection procedures. However, social services should consider whether the child and family would benefit from the provision of other services or support and whether the child fulfils the criteria for a "child in need".

CONCERNS REMAIN ABOUT SIGNIFICANT HARM

5.41 In some cases concerns may remain about significant harm, but there is not sufficient evidence to substantiate these at this stage. Consideration should, therefore, be given to the need for further investigation and assessment in order to decide whether the child is at risk of significant harm, is a child in need, or does not require any services.

CHILD HAS SUFFERED SIGNIFICANT HARM, BUT IS NOT AT CONTINUING RISK

5.42 There may be occasions when it is concluded that a child has suffered significant harm, but it is agreed between the agencies involved, the child and the family, that a child protection plan is unnecessary because the child is no longer at risk. This may be because circumstances have changed. For example, if a perpetrator of abuse has permanently left the household.

TAKING A DECISION NOT TO PROCEED TO A CHILD PROTECTION CASE CONFERENCE

5.43 Please note that care should be taken in reaching a decision not to proceed to a child protection case conference where it is known that a child has suffered significant harm. A designated person within social services at Programme Manager level should formally endorse such a decision and record their reasons on the child's case file. However, other professionals and agencies which have taken part in enquiries, have the right to request a child protection case conference, if they continue to have serious concerns about the child's safety. Any request made by a senior manager of another agency should normally be agreed, but ACPC procedures should be followed to resolve any remaining differences of opinion.

CHILD CONTINUES TO BE AT RISK

5.44 Irrespective of whether there is evidence of actual abuse, where it is considered that the child is at risk of significant harm, a child protection case conference must be convened. Its aim will be to enable those professionals involved with the child and family to assess all relevant information, and plan how to safeguard the child and promote his welfare.

INITIAL CHILD PROTECTION CASE CONFERENCE

5.45 The case conference should be convened by the Trust, or the NSPCC where there is an arrangement to this effect. It brings together the professionals involved after the completion of the initial child protection enquiries to:

- share and evaluate information gathered during the investigation;
- decide on the need for developing a child protection plan;
- decide on whether or not to include the child's name on the Child Protection Register.

TIMING

5.46 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 decisions based on evidence, it should take place following adequate preparation and 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 strategy discussion.** If this is not possible the Trust's Director of Social Work should approve the grounds for this delay and record this on the child's case file.

CHAIRING THE CASE CONFERENCE

5.47 Case conferences should be chaired by a senior member of staf f from the Trust, or the NSPCC, who has received training in this role. The status of the chair should be sufficient to ensure inter-agency commitment to the conference and the child protection plan. Wherever possible, the same person should also chair subsequent child protection reviews. T he responsibilities of the chair include:

- setting out the purpose of the conference and stressing the co nfidential nature of the information being discussed;
- enabling all those present to make their full contribution to the discussion and decision-making;
- ensuring that written reports are considered by the case confe rence;
- ensuring that the conference takes the necessary decisions; an d
- ensuring that proceedings are minuted and are circulated to all attendees.

ATTENDANCE

5.48 In order to decide what is needed to safeguard the child, case conferences should have all relevant information. Invitations should be sen t to all professionals and agencies that can contribute such information . They may include:

- social services or NSPCC staff;
- PSNI;
- PBNI (when involved);
- medical, nursing staff and allied health professionals;
- teachers and other education staff, e.g. education welfare officers;
- the Trust's legal advisers on child care matters;
- relevant foster carers and early years' providers;
- relevant voluntary organisations;
- the Co-ordinator or Senior Social Work Practitioner, SSAFA Forces Help Social Work Services where appropriate.

5.49 ACPC procedures should specify how the conference will be manag ed, the core members and the quorum required to take decisions. Those i nvited should be notified of case conferences as soon as possible, and it should be held at a time and place likely to be convenient to as many as possible.

INVOLVING THE CHILD AND FAMILY

5.50 Consideration should be given to involving parents and other fa mily members for all or part of the initial case conference. It is important to ensure that their presence does not inhibit the exchange of information by professionals, but where their co-operation can be obtained the future protection of the child may be facilitated by their participation. ACPC procedures should set out criteria for including or excluding a parent.

5.51 If a parent is excluded from the case conference he should be given the opportunity to make representations in writing. He should be notified of any decisions made by the case conference in writing.

5.52 When family members are invited, the social worker conducting t he investigation should, before the meeting, explain to them the case conference's purpose, who will attend, and how it will operate. The Chair should meet family members on the day of the conference and explain how the conference will be conducted and indicate who has been invi ted to attend. Where the family attends, they should be allowed to bring a friend or supporter and helped to fully participate. Where appropriate, the child should also be given the opportunity to attend and to bring a friend or supporter. Where the child does not attend, the social worker i nvolved should establish the child's wishes and feelings, and make thes e known to the conference.

5.53 Special arrangements may need to be made to enable all individu als to participate fully in the case conference. Where communication i s inhibited because of age, understanding, disability or language, consider ation should be given to providing an alternative means of communication inc luding the provision of an interpreter, signer etc.

INFORMATION FOR THE CONFERENCE

5.54 In advance of the case conference **all professionals invited** must provide a written report on their involvement with the family and their a ssessment of the child's needs and the parents' capacity to safeguard the ch ild. These reports should be made available to all those attending (see ch apter 8). The social worker should, in advance, help families and children to think about what they want to convey to the conference and how best to get their points across.

5.55 Social services should provide the conference with a written re port summarising the information obtained from the enquiries and the initial assessment undertaken in line with the Trusts' procedures. The report should include:

- details of the concerns that have led to consideration of the need for a child protection plan;
- information on the capacity of the parents and other family members to ensure the child's safety from harm;
- information on the child's past and current development;
- a chronology of significant events and agency and professional contact with the child and family;

- the expressed views, wishes and feelings of the child, parents, and other family members; and
- an analysis of the information obtained and the implications for the child's safety, well-being and development.

Parents and children, where appropriate, should be provided with a copy of the report in advance of the meeting. If necessary, its contents should be explained to them.

ACTIONS AND DECISIONS FOR THE CASE CONFERENCE

5.56 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. Conference participants should base their judgements on all available evidence obtained through existing records, the initial assessment, identified risks, enquiries and research. It should take into account the views of all agencies attending the case conference and any written contributions. ACPC procedures should give advice on the method of decision-making and actions to be taken to bring about change.

CHILD NOT AT CONTINUING RISK

5.57 Although a child may not be considered to be at continuing risk of significant harm, he may need continuing help and support to promote his health and/or development. In these circumstances, the case conference should ensure that arrangements are in place to consider with the family what further help and support might be offered. It may be appropriate to continue with a full assessment of the child's needs to decide which services are required to meet them. Where the child's needs are complex, inter-agency working will continue to be important.

CHILD AT CONTINUING RISK

5.58 Once a decision has been taken that the child is at risk of significant harm, his name should be placed on the Child Protection Register and the category of abuse should be determined.

5.59 Registration in itself will not offer protection to a child. It must be accompanied by a child protection plan. It is the responsibility of the case conference to make decisions about how agencies, professionals and the family will work together to ensure that the child will be safeguarded from future harm. The Chair of the case conference must ensure that the following specific tasks are agreed by the case conference:

- establishing the key elements of the child protection plan;
- appointing a case co-ordinator;
- identifying the membership of a core group who will develop the detail of the child protection plan;
- establishing if and how children, parents, and wider family members, will be involved in developing and implementing the child protection plan;

- establishing dates for completion of the comprehensive child p rotection plan, core group meetings and child protection reviews;
- identifying any specialist assessment of the child and family required;
- agree a review date within 3 months;
- the circumstances in which it might be necessary to call a review meeting before that date; and
- agreeing who else may need to be informed that the child' s name has been added to the Child Protection Register.

5.60 Parents and the child should also be told about what needs to happen before the child's name will be removed from the register.

APPEALS AND COMPLAINTS

5.61 ACPCs should have a procedure in place to enable parents to appeal against registration or de-registration decisions. ACPCs should also ha ve a procedure in place to enable all participants to make complaints if they believe that the procedures were not followed or the information available was i ncorrect.

5.62 Complaints about the conduct of individual members of the case conference should be dealt with by the relevant agency using its own compl aints procedure.

ADMINISTRATIVE ARRANGEMENTS AND RECORD KEEPING

5.63 All child protection case conferences should have in attendance a person trained to take notes and produce minutes of the meeting, which should include:

- a record of invitees, those who attended or sent apologies;
- a list of all reports considered by the case conference;
- the essential facts of the case;
- a summary of the discussion and analysis of information shared; and
- all decisions reached, including any dissenting views expresse d, and the action to be taken by everyone involved and timescales for each action.

5.64 Minutes should be sent within 14 days of the conference to all those invited to attend and the child's parents. Minutes are confidential and should not be passed to third parties without the consent of the conference Chair (see chapter 8). However, in cases of criminal proceedings, the poli ce are empowered to reveal the existence of the notes to the DPP.

5

AFTER THE CASE CONFERENCE

ROLE OF THE CASE CO-ORDINATOR

5.65 The case co-ordinator is responsible for:

- completing the comprehensive assessment of the child and famil y;
- developing the child protection plan, agreed at the initial ca se conference, into a comprehensive inter-agency plan based on the assessment before the first review (see paragraph 5.70);
- acting as the lead worker for the inter -agency work.

CORE GROUP

5.66 Membership of the core group should include the case co-ordinat or and other professionals who have direct contact with the family . Their role is to assist the case co-ordinator in developing the comprehensive ch ild protection plan and to fulfil any part identified for them in implementing it. The co-ordinator of the core group should also monitor progress in achieving the objectives specified in the plan.

5.67 The core group is an important forum for working with parents and children. Even when parents attend the case conference, it can often be dif ficult for them to agree to a child protection plan in such a formal setting. However , their agreement may be more easily obtained later when details of the plan are worked out by the core group.

5.68 The first meeting of the core group should take place as soon as possible after the initial case conference and thereafter as frequently as necessary to assist co-operative working, monitor activity and outcomes.

5.69 A written record of core group meetings should be kept.

ASSESSMENT

5.70 The comprehensive assessment should be completed in suf ficient time to enable the inter-agency protection plan to be devised at the first review case conference. It should:

- be conducted in line with the Trust's guidance on assessment;
- build on information obtained in the initial assessment; and
- address and develop the initial recommendations of the case co nference and incorporate additional issues coming to light through the c ore group's work.

CHILD PROTECTION PLAN

5.71 The key elements of the child protection plan should have been agreed at the initial case conference (see paragraph 5.45). Following the completion of the assessment, a comprehensive inter-agency plan should be developed by

the case co-ordinator, with the assistance of the core group. The aim of the plan is to:

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

5.72 The plan should:

- describe all aspects of the needs of the child, giving particular attention to his safety and well-being;
- identify the planned outcomes for the child;
- identify the help needed by the parents or other carers to safeguard the child based on an assessment of parenting capacity and the child's total environment;
- identify the means by which this help will be provided;
- highlight the risks associated with the course of action proposed and how these will be managed;
- identify the parts to be played by the professionals in providing this help and how the child's safety and well-being will be monitored; and
- set dates on which progress will be reviewed.

5.73 The parents should be given a written copy of the plan and the case co-ordinator should ensure that they understand it and are prepared to work towards its successful implementation.

5.74 The case co-ordinator should co-ordinate the work stemming from the child protection plan and all members of the core group should co-operate to achieve its aims. It is the responsibility of individual agencies to implement the parts of the plan specific to them and to communicate with the case co-ordinator and others as necessary.

CHILD PROTECTION REVIEW CONFERENCE

TIMESCALE AND ATTENDANCE

5.75 **The first review case conference should be held within three months of the initial case conference.** Further reviews should be held at intervals of **not more than six months** while the child's name is on the Child Protection Register. If any concern arises, any relevant professional may ask for a review to be convened. ACPCs should provide guidance on those who should be invited to attend the review.

PURPOSE

5.76 The purpose of the review is to:

- ensure that the child continues to be adequately safeguarded;
- review the outcomes for the child and how these align with tho se identified in the child protection plan;
- consider whether there is a continuing need for a child protec tion plan; and if so,
- consider the need for it to be amended.

5.77 Members of the core group should provide written reports for the review .

DE-REGISTRATION

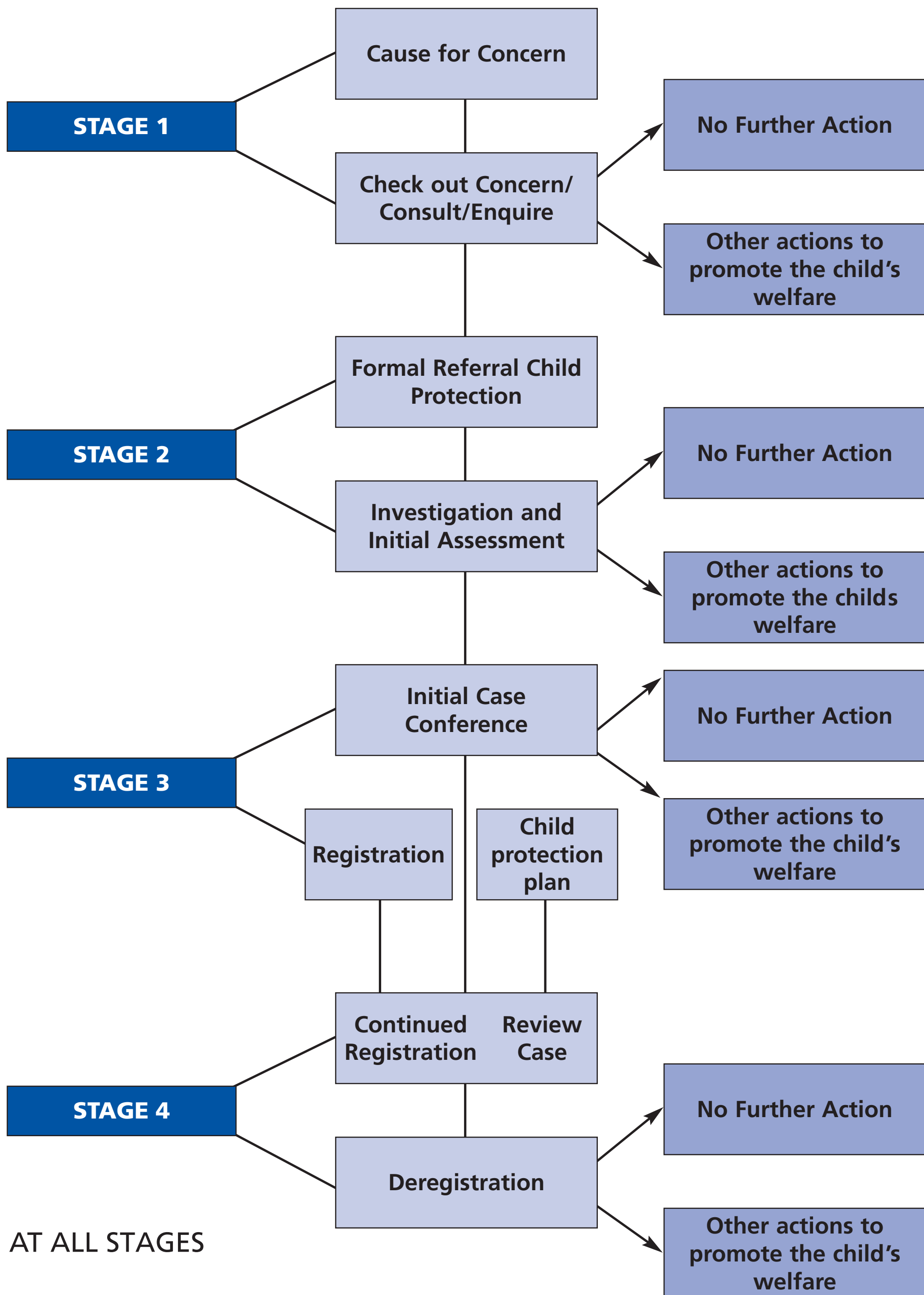
5.78 The need for continued registration must be considered at every review . The following criteria for de-registration should be considered:

- the comprehensive assessment has shown that a child protection plan is no longer necessary;
- the child has remained at home, but the risk of significant harm has been eliminated by work with the family under the child protection p lan;
- the child has been placed away from home and is no longer considered at risk of significant harm;
- the child no longer has contact with the abusing person;
- the child has reached 18 years of age, has married or has died; or
- the child has moved permanently to another area (see paragraph 5.88).

5.79 A child whose name is removed from the register may still be in need of additional services and de-registration should never lead to the automatic withdrawal of services, help or support. The case co-ordinator should discuss with the parents and the child what might be needed, based upon an assessment of their needs. The case co-ordinator should have si milar discussions with a young person approaching the age of 17 and e nsure appropriate services are provided once he is no longer covered by the child protection processes.

5.80 ACPC procedures should give guidance on the action to be taken when a decision is made to remove a child's name from the Child Protection Register to ensure that any agencies or professionals (e.g. schools, GP) who were informed of the decision to register are also informed of the decision to de-register, so that their records can be amended accordingly.

The Child Protection Process



AT ALL STAGES

1. Assess
2. Plan
3. Intervene (if necessary)
4. Review

CHILD LOOKED AFTER BY TRUST

5.81 Even though that same group of staff may be involved, separate reviews should be held for children who are both looked after by a Trust and on its Child Protection Register to ensure that the different issues relevant to each process are fully considered. There is, however, no objection to the two reviews being held consecutively, provided they are minuted separately.

PRE-BIRTH CHILD PROTECTION CASE CONFERENCE

5.82 Where there is concern that an unborn child may be at risk of significant harm, social services should convene a pre-birth case conference. It should be conducted in the same way as any other initial case conference.

CHILD PROTECTION REGISTER

5.83 Each Trust should maintain a register listing all the children resident in its area who are subject to child protection plans. Children's names should be entered on the register under one or more of the categories as determined by the case conference. It should be accessible to enquirers on a 24-hour basis.

5.84 The register custodian should be the Trust Director of Social Work who has responsibility for child care or a senior designated nominee. The register should be kept up to date and its contents should be confidential other than to legitimate enquirers. The identity of enquirers should always be checked before the information is provided. ACPCs should develop a policy on access arrangements, including recording register enquiries, and monitoring the effectiveness of the arrangements.

5.85 If an enquiry is made about a child and his name or the name of another child at the same address is on the register, the enquirer should be given the name of the case co-ordinator. The custodian should ensure that details of such enquiries are passed to the case co-ordinator. A record should be kept of any child not on the register about whom any enquiries are made. If an enquiry is repeated for any child, the need for a child protection investigation should be considered and decisions recorded.

5.86 The Child Protection Register for services' children in Northern Ireland is held by SSAFA Forces Help Co-ordinator at Headquarters Northern Ireland, Lisburn. A Central Forces Child Protection Register is held at SSAFA Forces Help Headquarters, London.

5.87 The DHSSPS holds a list of custodians of Child Protection Registers in Northern Ireland. Whenever a change is made this should be notified to Child Care Unit, Department of Health, Social Services and Public Safety, Room D1.4, Castle Buildings, Stormont, Belfast, BT4 3SQ so that the list can be kept up to date.

CHILDREN AND FAMILIES WHO MOVE

5.88 Where a child whose name is on the register moves to another address the Trust Director of Social Work (or senior designated nominee) should inform the Director of Social Work (or senior designated nominee) of the Trust in the area to which he has moved. Once that Trust has agreed to take responsibility for the child and placed the child's name on its register, the referring Trust should remove the child's name from the register. **In the case of a receiving Trust in Northern Ireland, the register custodian should ensure that the child is registered immediately and a case conference convened within 15 working days.** When a registered child moves to another jurisdiction, including the Republic of Ireland, similar action should be taken to notify the appropriate authority. The Trust Director of Social Work must ensure that a written summary of the family history and the reasons for registration should be forwarded within **5 working days** and make arrangements for the hand-over of responsibility for the case including ensuring that the other authority receives any other relevant information. Consideration should be given to forwarding a copy of the child's and/or family's case file. A record of the transfer of responsibility should be made, signed by the Director of Social Work and placed in the child's case file and a copy retained by the donor Trust. Trusts should be prepared to co-operate fully during the hand-over to ensure minimum risk to the child by for example, attending any case conferences that may be called.

5.89 Appendix 1 gives guidance on the movement of armed services families. Relevant contacts in the Health Boards in the Republic of Ireland are at Appendix 3.

5.90 Some families of children who are at risk of significant harm move home frequently. There is a real danger that such children may drop through the safety net. The register custodian should be responsible for instigating immediate action to trace families on the register who go missing. If local enquiries fail to trace the family, the Department of Social Development's offices or benefit branches may be able to provide an address from social security records.

5.91 If a child or family cannot be traced:

- if the child/family are thought to be in Northern Ireland the custodian should circulate details of the missing child/family to all the other register custodians;
- if the child/family are 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 & Public Safety
  Room D1.4
  Castle Buildings
  Stormont
  Belfast BT4 3SQ

  Child Care Unit will circulate the information to all custodians in Great Britain;
- if they are thought to be in the Republic of Ireland the custodian should circulate details of the missing child/family to the child care managers of all the Health Boards (see Appendix 3).

Child Protection in Specific Circumstances

6

INTRODUCTION

6.1 This chapter provides some additional guidance for dealing with allegations of abuse in specific circumstances.

STRANGER ABUSE

6.2 Offences against children, committed by strangers, should normally be investigated by the police as criminal matters. They should only lead to child protection investigations when there is reason to believe that the parents or an institution with a duty of care towards the child such as school, children's home or juvenile justice centre, is not responding to the incident adequately to safeguard the child from future significant harm. In other words, the justification for the use of the procedure is the concern that these individuals or bodies failed or are failing to protect the child, not the incident of abuse itself.

6.3 Although the investigation of abuse by strangers is primarily seen as a police responsibility, it is important that any child protection concerns, which arise during the course of the police investigation, should be referred to social services. Concerns may stem from inadequate parental supervision, which may have contributed to enabling the offence to occur, or the parental response to it may have been inadequate or inappropriate. Similarly, if the police consider that the child or family is in need of other services that could be provided by the Trust under Article 18 of the Children Order, a referral should be made. ACPCs should have procedures, specific to this issue, in place to ensure that children considered to be at risk of significant harm, or otherwise in need, are referred to social services.

CHILDREN LIVING AWAY FROM HOME

BASIC SAFEGUARDS

6.4 There are a number of elements of best practice that should apply in all settings where children live away from their family home. These are:

- children should be valued and respected and their self esteem promoted;
- alternative care settings should be open to external scrutiny by families and the wider community;
- alternative care settings should have child protection policies and procedures;
- staff should be trained in all aspects of safeguarding children. 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 institution and be aware of how to contact help line services, such as Childline;

- there should be complaints procedures appropriate for children. All complaints should be recorded together with their outcome;
- recruitment and selection procedures should be designed to prevent potential abusers from gaining employment in alternative care settings;
- there should be procedures to enable staff to express concern about the conduct of colleagues. The interests of "whistle-blowers" are now protected in law[4];
- there should be effective supervision, training and support for all staff; and
- staff should be aware of the vulnerability of children in their care to abuse by others, including peers.

INSTITUTIONAL CARE

6.5 Children living away from home in schools, children's homes, juvenile justice centres, or other institutions may be vulnerable to abuse by their peers. It may involve sexual or physical abuse, or any form of bullying. It is the responsibility of the agencies caring for children to safeguard them from abuse and, if it does occur, to take whatever action may be needed to protect them from further harm. If there is reason to believe that the agencies involved are not taking appropriate action, consideration should be given to using the child protection procedures to ensure children are appropriately safeguarded.

6.6 Abuse within institutions may precipitate children running away from them. Agencies represented on the ACPC should ensure that they have procedures for persistent absconders to be interviewed by someone independent of the institution to determine what led to them running away and to establish if abuse was a driving factor. ACPCs should encourage other agencies to adopt a similar procedure.

FOSTER CARE

6.7 The domestic and family nature of foster care can make it more difficult to identify abusive situations. Social workers visiting children in foster care should be alert to the possibility of abuse occurring within the foster home. They should see foster children on their own, encourage them to talk openly about their experiences and make a written record of these discussions.

6.8 Foster carers should know the whereabouts of their foster children at all times and ensure that they are kept safe. If foster carers are concerned about the well-being and/or safety of foster children, because of unauthorised absences, they should immediately inform their supervising social worker.

4 *The Public Interest Disclosure (NI) Order (1998)* protects workers who 'blow the whistle' about wrongdoing, from suffering detrimental treatment from their employer.

ALLEGATIONS OF ABUSE BY A PROFESSIONAL, CARER OR VOLUNTEER

6.9 Organisations that provide services for children including district councils, day-care, churches, leisure, sporting and community groups, organisations providing summer schemes or activities away from home, should have procedures for minimising the risk of child abuse and dealing with any complaints or allegations. The organisation's procedures should be consistent with ACPC procedures. *"Our Duty to Care",* the code of practice for voluntary organisations working with children, provides guidance on these issues. Individual staff and volunteers should be encouraged to share concerns which they may have about the attitudes and behaviour of colleagues with senior managers. Management and management committees should be prepared to treat such concerns seriously.

6.10 ACPC procedures should include guidance on the investigation of cases where an allegation is made, or a suspicion arises, that a member of staff has abused, or is abusing, a child who is the responsibility of his or her employing agency. Such circumstances include the alleged abuse of a child committed to a juvenile justice centre or one looked after by a Trust, but should also cover leisure and voluntary services.

6.11 In most cases where abuse is alleged there are two related, but independent strands; the enquiries into the need for child protection services and those into the criminal aspects of the allegation. In cases where it is suspected that a member of staff is an abuser, a third strand is the employer's responsibility to use disciplinary procedures to investigate what may amount to misconduct.

6.12 As with other possible child abuse concerns, social services should discuss the circumstances with the police at the first opportunity to determine how it will be investigated.

6.13 In situations where a Trust has parental responsibility for the child, it is important to consider whether it is appropriate for that Trust to conduct the child protection enquiry. Given that the Trust is, in effect, the parent of the child, the enquiry may need to consider whether the Trust has adequately discharged its parental responsibilities. If a decision is made by the Trust to carry out the enquiry, at least one independent person should be involved.

6.14 Although employers have a responsibility to consider the disciplinary implications arising out of such a situation, it is important that they should not conduct an investigation or gather evidence that could prejudice the criminal investigation (see paragraph 6.17). However, once the criminal process is completed, employers should consider the need to examine whether or not there are grounds for disciplinary proceedings for misconduct. The fact that the alleged abuser has not been prosecuted or has been found not guilty does not mean that such proceedings are not necessary or feasible.

6.15 However, given that the employing agency will not have conducted an investigation itself because of the danger of prejudicing the police enquiry, it is important that ACPCs should agree a procedure with the police to enable them to share relevant evidence gained during the criminal investigation with employers.

6.16 Where an allegation or suspicion of abuse arises involving a member of staff, employers should consider whether action is necessary to ensure that person does not have unsupervised access to children during the course of the investigation. In some cases where it is concluded that the staff member should be prevented from having access to children, it may be possible to find alternative duties for him. In others it may be necessary to suspend him from duty. All agencies should have procedures for suspending staff in such circumstances. If an agency is aware that a member of staff it has suspended also works with children for another organisation, either as an employee or volunteer, the agency should ensure that the other organisation is informed of the suspension.

6.17 Staff, about whom there are concerns, should be treated fairly and honestly and provided with support throughout the investigation process. Care should be taken to ensure that they are not presumed to be guilty. They should be helped to understand why the concern has arisen and be regularly informed about the progress of the investigation. However, the police should be consulted to ensure that nothing is said that would hinder the criminal investigation. Where staff are suspended it should be made clear that such a precautionary suspension will not prejudice any later disciplinary proceedings. See Chapter 9 for further guidance on staffing issues.

INVESTIGATING ORGANISED ABUSE

DEFINITION

6.18 For the purposes of this guidance, 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.

6.19 A range of abusing activity is covered by this term:

- **Paedophile Networks** - where several individuals create access to relatively large numbers of children. A network may be confined to a neighbourhood, may be spread over a wide geographical area or even across national boundaries. Some members may be known to each other while others remain anonymous;

- **Institutional Abuse** - is abuse by adults working in an organisation that has responsibility for children. The institution acts as an organisational base bringing adults and children together and offers the opportunities for the abuse to take place. Often a series of children are abused over a long period;

- **Family Based Abuse** - children are abused within an extended family network often crossing generations and involving several households. Adults outside the extended family may be drawn in and children may sometimes be prostituted. It differs from paedophile or child prostitution networks, not least because the victims are rarely recruited from outside the extended family and family contacts;

- **Child Prostitution and Pornography** - involves the sexual exploitation of children ranging from organised crime syndicates to young people who operate independently, although the latter would not be viewed as organised abuse.

6.20 These definitions are not necessarily exhaustive nor are they m utually exclusive. Categories of abuse may overlap.

INVESTIGATIONS

6.21 As with all types of abuse, investigation of organised abuse re quires thorough planning and good inter-agency working. It is also ess ential that appropriate resources are made available for investigations of this kind. ACPCs should have procedures for dealing with organised abuse cases. They should include provision for forming specialist teams to conduc t investigations. ACPC procedures should:

- state the agreed arrangements between police, social services and other agencies about all key operational matters;
- set out clearly the terms of reference for the team;
- include arrangements for safeguarding and storing records;
- emphasise the need for confidentiality;
- outline how senior staff from all agencies will be involved in the strategic management of the investigation; and
- state the parameters for dealing with media interest.

6.22 The Trust should ensure the team:

- is led by a senior manager with appropriate skills and trainin g;
- considers where any of the children involved need safeguarding and/or therapeutic help, how it can be provided in a way consistent with the criminal investigation;
- has access to records and individuals who hold relevant inform ation;
- has expert legal advice;
- has regular planning meetings; and
- is provided with managerial supervision and support.

6.23 The Trust should provide the ACPC with a written report of its findings and should agree with the ACPC how lessons learned can be dissemina ted appropriately.

6.24 Detailed guidance on organised child abuse can be found in *Grappling with Smoke – Investigating and Managing Organised Child Sexual Abuse – A Good Practice Guide (1998)* by Bernard Gallagher and published by NSPCC.

ABUSE OF CHILDREN WITH DISABILITIES

6.25 Safeguards for children with disabilities should essentially be the same as for other children. However, because of their disability, some children may be especially vulnerable to abuse. They may:

- be more compliant;
- have fewer outside contacts;
- receive intimate personal care which may both increase the risk of abusive behaviour, and make it more difficult to set and maintain physical boundaries;
- have an impaired capacity to resist or avoid abuse;
- lack knowledge about sex and sexuality;
- have communication difficulties which may make it difficult to tell others what is happening;
- be assumed to lack credibility as witnesses;
- be especially vulnerable to bullying and intimidation.

Nevertheless, where there are concerns about the welfare of a child with a disability they should be acted upon in accordance with the guidance in Chapter 5, in the same way as with any other child. However, if a child has a learning disability, sensory impairment or other disability that affects his ability to communicate, particular attention should be given to the need to involve someone with expertise in his disability. If possible, it should be someone he knows and trusts. (see paragraph 5.33).

CHILDREN WHO SEXUALLY ABUSE OTHERS

6.26 Whether a child is responsible for sexually abusive behaviour, is a victim of sexual abuse, or both, it is important to apply principles that remain child centred. Sexually abusive 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.

6.27 Most children who are responsible for sexually abusive behaviour are known to the victim and to the victim's family. The effects on victims, their families and often the community can be devastating. Guidance and procedures need to take account of both the victim and the child who abuses, the age of the children involved and the frequency and severity of the abusive behaviour.

EARLY INTERVENTION

6.28 Children and young people who abuse others should be held responsible for their abusive behaviour and other children and young people, who are at risk from them, need to be protected. However, they should also be responded to in a way which ensures that their individual needs are met. Many confirmed adult abusers began committing abusing acts during childhood or adolescence. However, it is important to note that many children and young people who display sexually abusive behaviour do not go on to become adult abusers. Early multi-agency intervention with children and young people who abuse others may, therefore, play an important part in protecting the public by preventing the continuation or escalation of abusive behaviour. It may also reduce the need to bring children before the court for criminal proceedings. The assessment of risk by and to the child who has engaged in sexually abusive behaviour should be facilitated through the child protection process. It is important to remember that children who abuse others can be and very often should be the subject of a child protection case conference.

PRINCIPLES

6.29 There are a number of principles which should guide work with children and young people who abuse others. These are:

- in the balance of what is in the child's best interests the needs of the victim must be given priority; and nothing should be done which causes the victim further harm;
- **the needs of children and young people who abuse others should be considered separately from the needs of their victims.**
- the child or young person involved in sexually abusive behaviour should be held accountable for their actions which may involve criminal prosecution. In determining accountability, attention should always be paid to the child's age, developmental stage and level of understanding;
- there should be a co-ordinated approach by child welfare and juvenile justice agencies. This should include appropriate communication between those professionals working with the victim and those working with the child who has abused;
- in each case a comprehensive/multi-professional assessment should be carried out which focuses on the specific needs arising from the abusive behaviour and individual developmental needs.

ACPC AND AGENCY RESPONSIBILITIES

6.30 ACPCs must ensure that there is a clear operational framework in place in which investigation, assessment, decision-making and case management can take place and procedures should reflect this. Sexually abusive behaviour, when identified in children or young people, must be taken seriously by all agencies and should be referred to either social services or to the police. When abuse of a child is alleged to have been carried out by another child or young person, an investigation should be carried out under ACPC child protection procedures and should consider separately the needs and welfare of the victim and the child who has abused.

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ASSESSMENT OF RISK AND NEED

6.31 It is important that allegations and incidents of sexually abusive behaviour by a child are investigated by social services. This may need to be done in collaboration with the police. There may be a need to establish a child protection plan and, where this is the case, the Trust should arrange a child protection case conference. This should be held separately from any child protection case conference held about his child victim. The child protection case conference should address:

- the nature and extent of the abusive behaviours. When sexual abuse occurs, there are sometimes difficulties in distinguishing between normal childhood sexual development and experimentation and sexually inappropriate or aggressive behaviour. Expert professional judgement may be required;
- the family and household composition and social circumstances and their capacity and ability to offer support and protection;
- the risks to self and others, including other children in the household/accommodation, extended family or social network;
- the child's or young person's developmental stage, level of understanding and acceptance that the behaviour is abusive;
- the child's or young person's need for services or support to address his offending behaviour and who is best placed to provide these;
- the extent to which information should be shared with those providing services;
- how service uptake and response to treatment by the child or young person responsible for sexually abusive behaviour will be monitored and measured;
- the potential impact of criminal prosecution on the child or other relevant parties;
- decisions which can inform future action by local agencies (including referral, where relevant, to restorative youth conferencing or court proceedings);
- if the child or young person is at risk of abuse or harm, whether there is a need for his name to be placed on the Child Protection Register and an inter-agency child protection plan drawn up.

6.32 Children or young people who are responsible for sexually abusive behaviour, will need help, and, in particular, access to specialist assessment and services, such as personal change programmes and counselling to reduce the likelihood that they will continue to abuse children as they mature. If,

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following abuse of another child, the child or young person can no longer live at home, the Trust, in consultation with the family and other relevant agencies, should immediately consider arrangements for his:

- accommodation;
- education; and
- supervision.

MULTI-DISCIPLINARY ASSESSMENT

6.33 A multi-disciplinary assessment should be carried out which assesses the level of risk, identifies the child's needs and, takes into account the child's age and stage of development and his likely response to personal change programmes to tackle offending behaviour.

ASSESSMENT TOOLS

6.34 It is essential to have a standardised and tested assessment tool for use by those who specialise in this area of work. ACPCs should adopt a common approach throughout the region and keep under review a suitable research-based model.

MODELS OF PRACTICE

6.35 Any restorative justice response or the use of the family group conferencing model should be well prepared and based on a thorough assessment of its suitability in each case. At no time should the child, who is responsible for sexually abusive behaviour, or his family, be allowed to avoid responsibility for his actions.

THE REQUIREMENT FOR SEX OFFENDERS TO REGISTER

6.36 The majority of children who are responsible for sexually abusive behaviour are not prosecuted. Only children over the age of 10, who have been convicted of sexually abusing others, will be required to register with the police. Therefore, the requirement of sex offenders to register can only go part of the way to provide a formal mechanism to manage risk.

6.37 Caution should be exercised when applying knowledge about adult sex offenders to children and young people. Children and young people who behave in a sexually inappropriate, or abusive way, often do not understand their actions in the same way that an adult sex offender does.

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INTERVENTION/TREATMENT

6.38 The goal of treatment is to change those identified risk factors that are amenable to change. In order to achieve such an outcome, a mult i-agency, multi-systemic approach should be actively considered and a str uctured 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.

Treatment programmes should be tailored to meet the individual needs of each child or young person.

BULLYING

6.39 A child who is bullied may also be suf fering any of the types of abuse covered in the definition in Chapter 2. It can take many forms, but the main types are:

- physical (e.g. hitting, kicking, theft);
- verbal (e.g. sectarian/racist remarks, name calling, threats);
- indirect (e.g. spreading rumours)

All settings in which children are provided with services or are living away from home should have rigorously enforced anti-bullying strategies and have policies and procedures in place to enable them to protect chil dren from bullying. The damage inflicted by bullying can frequently be un derestimated. It can cause considerable distress to children, to the extent that it af fects their health and development or, at the extreme, causes them significant harm. In extreme cases it will be important for the inter -agency network to make a concerted effort to eliminate bullying to safeguard children. Where necessary the use of child protection procedures should be considered.

DOMESTIC VIOLENCE

6.40 Domestic violence affects **all** members of a household. Children living in households where there is domestic violence may suf fer both directly and indirectly and are likely to be children in need. Where there is evidence of domestic violence, the possibility of the children being subject to violence, or

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other harm, should be considered. Given the vulnerability of children they are particularly susceptible to the impact of domestic violence and it may effect their emotional, psychological, physical and sexual development. In domestic violence situations professionals must ensure they maintain a clear focus on the child's welfare. Protecting children from domestic violence is a multi-agency responsibility.

6.41 Many children who have experienced domestic violence meet the definition of "children in need" as outlined within the Children Order. Professional judgement must determine when to make an onward referral to another agency, whether for family support or child protection reasons. Research findings correlate the incidence of domestic violence and child abuse. Professionals must, therefore, be alert to the likelihood that child protection issues may be present. When there are grounds to believe that a child is suffering, or likely to suffer, significant harm the referral and investigation process under child protection should be instigated.

THE FAMILY HOMES AND DOMESTIC VIOLENCE (NORTHERN IRELAND) ORDER (1998)

6.42 The Family Homes and Domestic Violence (Northern Ireland) Order (1998) tackles two separate but inter-related problems; providing protection for one family member against violence or molestation by another and regulating occupation of the family home where a relationship has broken down.

- Article 28 inserts a new article into the Children Order (Article 12A) to ensure that where there has been domestic violence in a home, the court must consider the risk of harm to the child witnessing domestic violence before making a residence or contact order. When a court is considering whether or not to make a contact or residence order in favour of someone who has a non-molestation order made against him, the court will have to consider whether the child is at risk of harm as a result of seeing or hearing the ill-treatment of another person if the order is made.

- Article 29 inserts two new articles into the Children Order (Articles 57A and 63A) which give a court the power to remove a suspected abuser from the family home instead of removing the child under an interim care order or emergency protection order.

6.43 When responding to incidents of violence, the police should find out whether there are any children living in the household and if so, consider whether there is a need to notify social services. The ACPC should ensure that there are arrangements in place between police and social services, to enable the police to find out whether any such children are on the Child Protection Register. In extreme cases, a child may be in need of immediate protection.

6.44 The Family Homes and Domestic Violence (NI) Order provides for occupation orders and exclusion orders which determine who is allowed to occupy the home and can direct another person to leave. They may prove helpful in excluding abusers from a household.

SUBSTANCE ABUSE

6.45 Children can need safeguarding because of substance abuse. If they are provided with substances such as alcohol, solvents or illegal d rugs by a parent or carer, this action may constitute physical abuse. However, the abuse of such materials by parents or carers themselves may result in them being incapable of providing the level of care needed by a child. In cases where there is evidence to suggest that parents or carers may be abusing substances to an extent which may impair their ability to care for the chi ld, consideration should be given to the need for a child protectio n investigation on the grounds of neglect. Substance and alcohol misuse by parents should always be taken into consideration when assessing parenting com petence and elements of risk to any child.

COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN

6.46 In most countries, including Northern Ireland, there is evidenc e of children being sexually exploited through prostitution. In some instances they may be visible on the streets, but in many they are not, so the size of the problem is difficult to judge. Nonetheless, the problem of exploitation an d abuse through prostitution does exist.

6.47 The guidance in this section is intended to ensure that all agencies involved work together to:

- recognise the problem;
- prevent children from being exploited and abused through pros titution;
- treat children primarily as victims of abuse;
- safeguard them and promote their welfare;
- provide them with opportunities to escape sexual exploitation and abuse through prostitution; and
- investigate and prosecute those who coerce, exploit and abuse children through prostitution.

6.48 The guidance builds on the lead given by the Association of Chief Police Officers (ACPO) in developing guidelines for the police in asso ciation with the children's charities, government departments and the Associatio n of the Directors of Social Services. The ACPO guidelines have been suc cessfully piloted in Wolverhampton and Nottingham, and now form ACPO's national policy. Further guidance on this subject is available from the Department of Health. The guidance, *Safeguarding Children Involved in Prostitution (2000),* is aimed at police, health, social services, education and all other agencies and professionals that may work with children about whom there are concerns that they are involved in prostitution.

6.49 It is important to recognise that a child exploited through prostitution cannot be considered to be a miniature adult, capable of making the same informed decisions as an adult can about entering and remaining in prost itution. Increased awareness and research has shown that the vast majority of

children do not enter into prostitution willingly and that their involvement is indicative of coercion or desperation rather than choice.

6.50 Children should not be involved in prostitution and it is important that proper prevention, protection and rehabilitation strategies are put in place. All professionals should be able to recognise situations where children might be involved in, or are at risk of becoming involved in, prostitution. They should treat such children as children in need, who may be suffering, or may be likely to suffer, significant harm. Agencies coming into contact with these children have a responsibility to safeguard and promote their welfare and to co-operate effectively to prevent children becoming involved in, and divert them out of, prostitution. The identification of such children should always trigger the agreed ACPC procedures to ensure the child's safety and welfare, and to enable the police to gather evidence about abusers and coercers.

6.51 This guidance confirms the ACPO policy that the primary law enforcement effort should be against people who draw children into prostitution (coercers) and against "clients" who sexually exploit and abuse them. For children, the emphasis must be to prevent their entry into prostitution if this has not already happened. Where children are already actively involved, the priority must to be to protect them from further abuse by helping them to get out of prostitution. Nevertheless, there may be occasions, after all attempts at diversion have failed, when it could be appropriate for those who voluntarily continue to commit offences, such as soliciting or importuning, to be treated as young offenders.

HOW CHILDREN BECOME EXPLOITED THROUGH PROSTITUTION

6.52 Children who are exploited through prostitution come from many backgrounds. Children of both sexes can become involved. Some children may be living at home, others may be living away from home (such as in residential care or foster care), or have run away and are homeless. There is no single pattern. The most common factors are vulnerability and low self-esteem. These may result from a multitude of factors, including difficult or abusive childhood experiences or educational under achievement. Other factors may include pressure from peers or others already involved in prostitution (including other family members) or drug/alcohol misuse. Absence from school frequently or for protracted periods, through truancy or exclusion, may make children especially vulnerable.

6.53 It is important to recognise that young people, particularly girls, may be physically and emotionally dependent on the coercer despite the violence endured, for the sake of "love". The fact that outsiders would consider this a delusion does not make it any less real for the individual concerned. Although the young person may claim to be acting "voluntarily", in reality this is not voluntary or consenting behaviour. When working with young people, all agencies must appreciate the strength of this attachment and the time and difficulty there may be in breaking it and helping the young person to attach to appropriate adults.

6.54 Children exploited through prostitution may not necessarily be found on the streets. Many are kept in rooms and flats, sometimes against their will. Children in this situation are not breaking the law; their coercers and abusers are. The coercers operate by finding "clients" and bringing them to the children. "Clients" who assume that payment buys the agreement of the child and puts them beyond the law are completely wrong - they are child

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abusers liable to prosecution for a range of of fences. All agencies should establish whether those who are known to pay for sex with children are themselves parents or carers of children. If this is the case, an assessment of the needs of those children should be considered which should i nclude establishing whether they are at risk of, or are suf fering, significant harm.

IDENTIFYING CHILDREN EXPLOITED THROUGH PROSTITUTION

6.55 Parents or carers may become aware of and concerned about a child's relationship with an older person (whom the child may describe as a "friend", whether male or female) and/or frequent absences from home/school, and report their concerns to the police and/or soc ial services. These concerns should always be taken seriously and the possibi lity considered that this pattern of behaviour could be part of a gr ooming process intended to draw the child into prostitution. The polic e should consider whether charges, such as unlawful carnal knowledge or child abduction, are appropriate.

6.56 Children living away from home, in particular those living in residential care, may be targeted. Staff working in residential settings may become aware that children are being picked up regularly by unauthorised old er persons in cars, or that there are individuals loitering around outside the residential establishment to meet children. They may become aware that children are receiving expensive gifts and are reluctant to disclose the source. These people and events should always be reported to a senior manager responsible for the residential establishment and to the police . The reports should always be taken seriously and investigated. Reporting pr ocedures should be well known within the residential home.

6.57 In many cases, appropriate responses by the police and residential social workers may disrupt this abusive pattern and provide protection for the children. However, police and social services staff should be aware that once concerns have been reported, the child may continue to be at risk from coercers and urgent action to safeguard them may be required. I t is shown from research that looked after children who run away are particularly at risk of sexual exploitation. Trusts should monitor carefully the incidence of looked after children who go missing, particularly from residential ca re. ACPCs should have procedures in place with the police and other agenc ies on the action to be taken whenever a child goes missing and when he re turns. *Missing from Care (1998),* a report of a joint Local Government Association and ACPO working party in England, sets out recommended procedures and practices in caring for missing children and provides a basis o n which procedures may be based.

6.58 Children exploited through prostitution may also come to the attention of the police in the course of their duties, such as during the investigation of drug offences, or in the execution of search warrants. In these circumstances, police officers should be aware of the need to take, if necessary , immediate steps to safeguard the child, and to initiate the procedures relating to children exploited through prostitution.

6.59 Other professionals may become aware of children who are at risk of exploitation through prostitution. For example, if teachers see significantly older 'boyfriends' collecting girls from school they have a duty to report their concerns to the designated teacher. Similarly, health professionals, particularly those working in genito-urinary medicine, sexual h ealth and

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pregnancy advisory services should consider the possibility of the exploitation of a young patient through prostitution and follow the procedur es laid down in ACPC guidance.

6.60 The exploitation of a child through prostitution may come to the notice of agencies or professionals through patterns of behaviour related to drug misuse. Specialist drug agencies and outreach workers will have an important role to play in identifying children who are being exploited th rough prostitution as a means of raising funds to purchase drugs. Sim ilarly, a child may also have relevant physical symptoms e.g. sexually transmitted infections. Child and mental health professionals are also likely to identify or suspect instances where a child is being exploited through prostitution . For health professionals in all of these services it will be important always to make a holistic assessment of the needs of the child and to be aware t hat consultation with social services may be necessary.

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

6.62 Paragraph 4.14 requires ACPCs to develop local procedures to cover a range of subjects, including their responsibility to children exploit ed through prostitution. In particular, the ACPC should:

- actively enquire into the extent to which children are being exploited in its area;
- develop local procedures for dealing with the exploitation of children through prostitution; and
- provide a local source of expertise for professionals who have reason to believe a child may be being exploited and abused through prost itution.

6.63 The inter-agency procedures should outline the processes (and p ossible responses) for dealing with a child once he has been identified as being at risk of being the victim of exploitation through prostitution. The procedures should stress the importance of ensuring that information about a child is shared appropriately with all relevant agencies. They should emphasise the sensitivity of the issues under discussion and the need to ensure that the confidentiality requirements applying in all child protection w ork under the aegis of the ACPC are fully complied with.

6.64 The procedures should also recognise that the child is an impor tant contributor in addressing these issues. Children may be at a pa rticularly important turning point in their lives and will need to be 'ena bled to express their wishes and feelings; make sense of their circumstances and contribute to decisions that affect them' (NSPCC, 1997). The creation of a successful exit strategy and reintegration into a life free from abuse and exploitation through prostitution are dependent on working with the child to construct a plan that he can agree to. Wherever possible, family members should also be involved in work with the child.

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6.65 Children who are exploited through prostitution may be difficult to engage, and be under very strong pressure to remain in prostitution. They may be fearful of being involved with the police or social services and may initially respond best to informal contact from health or voluntary sector outreach workers. Gaining the child's trust and confidence is vital if he is to be safeguarded and enabled to exit from prostitution.

CRIMINAL JUSTICE ACTION

6.66 The priority for criminal justice action must be to investigate and prosecute those who abuse a child (this includes those who sexually abuse a child and those who coerce or are involved in the prostitution of a child). The interests of the child should be taken into account and, as in all cases involving children as victims and witnesses, the case will need to be handled with care and sensitivity. The child should be encouraged to contribute to the investigation. In addition, consideration should be given to the provision of witness support services.

6.67 All agencies involved with the child should be meticulous in their note keeping and record carefully any information that could be used to assist the bringing of charges against those exploiting the child. This could take the onus of being the principal witness against the abuser from the child. Where coercers are powerful and organised there is a significant risk of intimidation of the child and the family. Both may need protection and assistance through witness protection programmes.

6.68 Child witnesses in cases involving violence, or sex offences, may be assisted to give evidence in court through the use of video recorded statements, admitted as evidence-in-chief, and the use of live TV links for cross-examination so that the witness does not have to face the defendant in court. (see paragraph 5.37).

VOLUNTARY AND PERSISTENT RETURN TO PROSTITUTION

6.69 In most parts of the UK, some activities associated with prostitution, including soliciting, loitering and importuning are criminal offences, although some of the offences apply only to certain localities. The majority of children do not freely and willingly become involved in prostitution. However, it would be wrong to say that a boy or girl under 17 never freely chooses to continue to solicit, loiter or importune in a public place for the purposes of prostitution. In such cases, the police should only start to consider whether any criminal justice action is required, following a strategy discussion when all diversion work has failed over a period of time, and a judgement is made that it will not prove effective in the foreseeable future. What constitutes "a period of time" and "the foreseeable future" will vary in each case.

6.70 The initial presumption should always be that a child is not soliciting voluntarily. What seems to be a persistent and voluntary return to soliciting should never be taken at face value. There must be a thorough investigation of all aspects of a case to ensure that there is no evidence of an abusive relationship that could involve physical, mental or emotional coercion. There should also be a shared conviction of those involved in the inter-agency discussion that an individual's return to prostitution is of their own volition.

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6.71 The criminal justice process should only be considered if the child persistently and voluntarily continues to solicit, loiter or importune in a public place for the purposes of prostitution. Police, and colleagues in other agencies, who will consider whether there is a genuine choice, must be aware of the high degree of coercion and malign influence that can be exercised by abusers and be fully open to the possibility that what is claimed as a voluntary activity simply masks threats or coercion.

6.72 Persistence is generally understood in law to require a determined repetition of an activity. It is not appropriate to define persistence more closely as each case should be considered in context. A determined and regular return to soliciting, loitering or importuning over a period of time would, however, be regarded as persistent. In practice a child who uses prostitution to satisfy a need for drugs, is likely to meet the criterion of persistence. In such cases the relationship between the coercer, prostitution and drug misuse requires careful analysis and consideration. It should be borne in mind that it may be very difficult to break the control of the abuser established though a high level of physical violence and fear. Consideration should be given to initiating proceedings for care or supervision under Article 50 and Article 54 of the Children Order in order to safeguard and promote the child's welfare.

6.73 The decision on whether to initiate criminal justice action is for the police, and at a later stage, the DPP. In the context of this inter-agency approach, unilateral action by the police would not be appropriate. If police officers consider that it would be appropriate to pursue criminal justice options, then inter-agency discussion should take place within ACPC procedures.

6.74 Police should not normally take criminal justice action unless there has been inter-agency discussion to consider the full circumstances of each case and it is agreed that all other avenues had been explored. Particular attention should be given to the following factors:

- the age and vulnerability of the child;
- the needs of the child;
- any drug misuse by the child;
- that the return is genuinely voluntary and that there is no evidence of physical, mental or emotional coercion; and
- that the child understands that criminal proceedings may follow, and the effect these may have in later life.

THE RISKS POSED BY DEVELOPMENTS IN COMMUNICATIONS TECHNOLOGY

6.75 The Internet has become a significant tool in the distribution of child pornography. Material passing over the Internet is subject to the same laws as material being distributed by other means (i.e. what is illegal off-line is illegal on-line). As well as abusing the Internet to distribute child pornography a number of adults are also misusing chat rooms on the Internet to try and establish contact with children. Chat rooms create a particular problem because they occur in real time and there is no record of the material held.

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The need to educate children to be street-wise on the Internet is vital. When somebody is discovered to have used the Internet to access or distribute child pornography, the police and social services should consider whe ther the individual might also be involved in the active abuse of childr en.

6.76 Given the speed of technological change, including developments in mobile phone technology, it is important that ACPCs consider ongoing a ctivities to raise awareness about the safe use of communications technology, including the Internet, by children e.g. by distributing information thro ugh education staff to parents, in relation to both school and home-based use of computers by children.

SUDDEN UNEXPECTED DEATH IN INFANCY

6.77 Sudden Unexpected Death in Infancy (SUDI) is also sometimes ref erred to as Cot Death. Whilst it is true that impact of social circumstance s, particularly in relation to unexplained deaths is very large there are still ma ny practical steps that can be taken to safeguard children in *all* homes. The number of deaths classified as SUDI continues to fall[5] largely as a result of identified risks, including inappropriate sleeping arrangements. It remain s a matter of concern, however, that the deaths of so many children remains p oorly understood and investigated. Unless the cause of a problem is u nderstood there is little chance of prevention or cure. Studies in many countries over the past 30 years have shown that most at risk are babies who are premature, of low birth weight or from multiple births; whose mothers are young, poorly educated, live in poor conditions, smoke, leave little interval between pregnancies, whose fathers are absent or unemployed. Deaths are uncommon in the first month of life, rise abruptly to a peak at about 10 weeks, then rise more gradually, becoming infrequent after 6 months and very unu sual beyond a year. Deaths usually occur during the night and are more frequent in the winter months. Boys are more vulnerable than girls, and some ethnic groups are less vulnerable than others.

6.78 While the vast majority of such deaths are unavoidable there may be some which involve an element of neglect or abuse by carers. These range from overuse of 'over the counter' medicines to homicide. It is essential that procedures for investigating and establishing the causes of death are fully complied with by all professionals. If there is evidence that the death is not as a result of natural causes, consideration should be given to in stituting enquiries to ensure that any surviving siblings are adequately safeguarded. A protocol for this kind of investigation has been developed by a multi-agency/multi-disciplinary group which includes representatives of the Coroner's office, PSNI, Paediatric Pathology, Paediatrics and DHSSPS. This needs to be referenced by ACPC procedures.

5 Golding, J, Limerick,S and Macfarlane, A. *Sudden Infant Deaths: Patterns, Puzzles and Problems.* Shepton Mallet: Open Books, 1985:22-102.

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Offenders Against Children

7

INTRODUCTION

7.1 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 abuse them. This work may include contributing to treatment programmes intended to reduce the risk of further offences, particularly those likely to be committed by young people. It will also require the sharing of information with other agencies to help identify and supervise people who have been convicted of, or charged with, offences against children, or in exceptional circumstances, those suspected of committing such offences.

7.2 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. The following section gives guidance on the procedures for sharing information in these cases. Schedule 1 offences include both sexual and other forms of abuse. Different arrangements exist for these two categories.

DISCLOSURE OF INFORMATION

7.3 Disclosure of information about those who abuse children, especially sex offenders, raises some very sensitive and far-reaching issues. Information should not be handed out gratuitously, but assessment of risk is at the heart of the process set out in this guidance. It is essential, therefore, that information is shared amongst the agencies involved in child protection and risk assessment work in accordance with guidance. While there is a need to protect the rights of the individual, the protection of children must be the overriding concern. However, it should be borne in mind that there is often intense negative public interest in people who have committed offences against children, particularly sexual ones. It is not unknown for journalists to use subterfuge to gain information about them. If requests for information are received from other agencies the *bona fides* of the caller should be checked by, for example, arranging to telephone back. No information should be provided to the press without the explicit agreement of senior staff of all the agencies involved.

7.4 The case law on the sharing of information is not entirely clear as is illustrated by the following extracts:

R v Norfolk County Council

A 13 year old girl alleged that a man had indecently assaulted her while he was working at her parents' home. He denied the allegation and the police decided to take no further action due to lack of evidence. A case conference decided to place the girl's name on the Child Protection Register. The man's name was also added as a "known/suspected abuser". He was told of this, but not that his employer had also been informed. He applied for a judicial review of the decision. **The court held that the case conference had acted unfairly, unreasonably and in breach of natural justice in deciding he was guilty after a brief one-sided investigation, in denying him the opportunity of objecting to the decision, in failing to make a distinction between known and suspected abusers on its register and in putting secret pressure on his employers.**

R v Devon County Council

Social workers passed on allegations that a man had sexually abused a child in one household, to two households into which he subsequently moved. He instigated a judicial review of the Council's actions. The court held that the social workers' overriding duty was the protection of children. Although the alleged abuser had not been prosecuted, they honestly believed, on reasonable grounds, that he had abused a child and was likely to do so again. In those circumstances the court held that they were right to tell other families vulnerable to abuse of their suspicions. **The judge concluded that in balancing adequate protection for the child and fairness to an adult, the interests of the adult may have to be placed second to the needs of the child.**

R v Down Lisburn HSS Trust

In R v Down Lisburn HSS Trust, Weatherup J defended the retention and disclosure of information relating to allegations of sexual abuse. These had not resulted in criminal proceedings and were made by a child from an earlier relationship. The information was retained on social services record system and had been disclosed by the applicant to a new partner, the mother of 3 children, both at the request of and in the presence of social services staff. The subject of the allegations (the applicant) sought a judicial review of the decision by the Trust to (a) retain records of allegations against him; (b) require the disclosure of the information; and (c) refuse not to disclose the information to third parties in the future.

Weatherup, J adopted the analysis of key questions from R v Chief Constable of the North Wales Police ex parte AB [1999] QR 396: *a judicial review of the policy of the police to make disclosure of the identity of convicted paedophiles to the owner of a caravan site where they were resident;* R v Local Authority and Police Authority in the Midlands ex parte L M [2000] 1 FLR 612: *a judicial review by the police and social services of allegations of sexual abuse;* Re S (Sexual abuse allegations – Local Authority response) [2001] 2 FLR 776: *a judicial review of a disclosure decision concerning a risk to specific children.*

Weatherup, J concluded that the Trust had reasonable cause to suspect the applicant's new partner's children would be likely to suffer significant harm and had grounds to conclude that action was required to safeguard the children's welfare. The Trust was found to have made an assessment based on the facts and circumstances of the particular case. A pressing need for disclosure was established. A balance of the considerations affecting the applicant's interests and the public interest had been carried out by the Trust. The materials presented by the Trust led the judge to believe that there was no blanket disclosure policy in operation. Further the measure adopted of requiring disclosure to the new partner was found to be necessary in the circumstances. In addition the Trust had involved the applicant in the exercise by requesting his attendance at a meeting to explain the proposed action and to involve the applicant in the actual disclosure.

The judge found that the Trust had provided substantial justification for its actions both for the purposes of Article 8 of the Human Rights Act and for the purposes of irrationality had it been a specific ground of challenge. He also found that the actions of the Trust were equally necessary for the purposes of the exercise of its statutory functions as required by the schedules of the Data Protection Act (1998). Finally he concluded that the Trust remained entitled to retain its records and to judge any future action in accordance with the pressing need and other factors discussed above as they apply to the facts as they then exist in the particular case at that time.

R v North Wales Police

The court held that although there is a general presumption that the police should not disclose information about offenders to third parties, they could do so in order to prevent crime or to alert members of the public to a potential danger. The court considered that it was right for the police to make such limited disclosure as they judged necessary to achieve this purpose. However, the judgement states that blanket disclosure policies are objectionable and that any decision to disclose must depend upon a careful consideration of the facts of the case, the nature of previous offending and the risk of further offending. **The court also considered that disclosure would not contravene Article 8 of the European Convention on Human Rights (right to respect for privacy and family life) where disclosure was made in good faith in the exercise of professional judgement and limited to what was reasonably necessary.**

7.5 It is therefore, important that information should only be shared where staff have sufficient evidence to justify their belief that a specific individual has committed an offence. Where the information concerns a person suspected of committing an offence, but not convicted of it, he should be informed of the allegations made against him and given the opportunity to make representations to the main co-ordinating agency prior to information being shared about the risk posed to children.

7.6 All persons about whom information is shared, whether convicted, charged or merely suspected of committing offences against children, have the right to know that:

- a record of their status is held;
- they may be asked to co-operate with professional staff to assess the likelihood of future harm to children;
- they may be asked to work with professional staff to reduce the risk of future harm to children;
- information about their offending histories may be disclosed to other agencies on a need to know basis;
- (in some circumstances) their offending histories may prevent them from gaining paid or voluntary work with children;
- if they are planning to live in, or regularly visit, a household where there are children, another person, parent or guardian may be informed about their offending histories; and

- in every case the decision to inform a third party of the of fending history will take into account the rights of the person believed to present a risk to children.

RISK ASSESSMENT AND MANAGEMENT - PHYSICAL AND EMOTIONAL ABUSE AND NEGLECT

7.7 This section applies only to non-sexual abuse cases and aims to cover those situations where significant harm to a child prompts assessment and management of risk procedures to avoid further abuse.

7.8 Risk assessment and management may be necessary:

- following a case conference on an individual child;
- where a non-custodial sentence has been imposed;
- where there is a general concern about a person in the commun ity; or
- when an offender is released from custody or from prison.

7.9 A risk assessment and management meeting should be convened by one of the following agencies:

- Prison Service - prior to release of the of fender;
- PSNI - where an of fender has been released from custody or pr ison;
- PBNI - where an of fender is subject to community supervision;
- Social Services - where there is a referral from the community or following a case conference.

7.10 The core members of the risk assessment and management meeting should include:

- PSNI;
- PBNI;
- Social Services; and
- Prison Service (where appropriate).

7.11 Where appropriate, a psychologist or a psychiatrist with knowledge of the case should be invited to attend the risk assessment meeting to provide advice.

7.12 The core members of the risk assessment and management group should make a decision on the risks of an individual having contact wi th children and make recommendations for action. They should:

- exchange information;

- assess the risks to children;
- decide if services or treatment that may reduce the risk of re-offending would be appropriate and who should provide them;
- appoint a case co-ordinator from the agency with continuing responsibility for the management of the offender to act as a contact point for the exchange of information, to alert relevant agencies to any changes of address or relationships and to reconvene the meeting when required;
- record the discussions and decisions;
- decide on whether disclosure of the information is appropriate and to whom and for what purpose;
- refer media requests for information to senior managers; and
- allocate responsibility for informing the offender of the risk assessment, recommendations and the implications for him.

7.13 Following the initial assessment, other agencies which may be able to contribute to the management of identified risks should be invited to attend the core group meetings.

7.14 Risk assessment and management decisions should be based on a consensus decision by all the parties present. Where this is not possible it should be a majority decision. All decisions must be recorded, endorsed and shared between the agencies and the individual.

SEX OFFENDER RISK ASSESSMENT AND MANAGEMENT

7.15 The following outlines the action to be taken when dealing with people suspected, held, charged or convicted of Schedule 1 sexual offences against children. It details who will carry out the initial classification of risk and when to refer the case to the appropriate Sex Offender Management Committee.

7.16 The Northern Ireland Sex Offender Strategic Management Committee is responsible for planning at a region wide level and for direct oversight of the highest risk cases. It is chaired by the police and composed of senior managers from PBNI, Prison Service, Health and Social Services Boards, the Northern Ireland Housing Executive, the voluntary and education sectors.

7.17 There are six Area Sex Offender Risk Assessment and Management Committees. They are responsible for carrying out risk assessments of sex offenders, for co-ordinating information and for agreeing and reviewing risk management plans. They are composed of representatives of the police, PBNI, Prison Service, Trusts and other agencies as necessary.

7.18 Risk assessment is based on a person's behaviour, not their personality traits. Unlike such traits, behaviour can be changed and managed because it can change as a result of a range of influences. The NIO manual, *Multi-Agency Procedures for the Assessment and Management of Sex Offenders,* provides a framework for this assessment which results in the offender being classified in one of 3 categories.

They are:

Category 3 someone whose sexual offending has been assessed as currently likely to lead them to seriously harm other people;

Category 2 someone whose behaviour gives cause for clear concern with regard to their capacity to carry out a contact sexual offence;

Category 1 someone whose behaviour gives no current cause for concern with regard to their capacity to seriously harm other people or carry out a contact sexual offence.

The NIO manual gives detailed guidance on the Sex Offender Management Committees and on risk assessment.

Record Keeping, Confidentiality and Sharing Information

8

RECORD KEEPING

8.1 Good record keeping is an important part of a professional's task. Records should use clear, straightforward language, be concise, and accurate. They should clearly differentiate between facts, opinion, judgements and hypothesis.

8.2 Well-kept records are essential to good child protection practice. Safeguarding children requires information to be brought together from a number of sources, and careful professional judgements to be made on the basis of this information. Records must be clear, accessible, and comprehensive. The subject of a record does have the right in law to request access to them at any stage. Judgements made, actions and decisions taken should be carefully recorded. Where decisions have been taken jointly across agencies, or endorsed by a manager, this should be made clear on the case records.

8.3 Relevant information will normally be collated in one place by social services. Records should clearly provide the chronology of the case and should demonstrate how the process has been managed by the professional and indicate how actions taken and decisions made have been endorsed by line managers and senior managers. Specifically, the reader should be able to track the plan for the case through:

- the information about the child and family and actions taken from referral through interventions to outcome and closure of the case;
- identified and potential risks of harm, the source of harm and those at risk;
- the intended outcome for the child, the interventions which have taken place, by whom and the reasons for intervention;
- the evidence that change has taken place; and
- an analysis of the progress that is being made.

8.4 Each agency should ensure that when a child moves outside its area the child's records are transferred promptly to the relevant agency in the new locality. Cases where enquiries do not substantiate the original concerns should be retained in accordance with the agency's record retention policy. This policy should ensure that records are stored safely and can be retrieved promptly and efficiently (see paragraph 5.88).

CONFIDENTIALITY AND INFORMATION SHARING

8.5 Research and experience 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; and

- those who may pose a risk of harm to a child.

Often, it is only when information from a number of sources has been shared that it becomes clear that a child is at risk.

LEGAL FRAMEWORK

8.6 Personal information about children and families held by professionals is subject to a duty of confidence, and should normally not be disclosed without the consent of the subject. **However, the law permits the disclosure of confidential information necessary to safeguard a child.**

8.7 Professionals can only work together effectively to safeguard children, if there is an exchange of relevant information between them. This has been recognised in principle by the courts. Any disclosure of personal information to others must always, however, have regard to both common and statute law.

8.8 Normally, personal information should only be disclosed to third parties (including other agencies) with the consent of the subject of that information. Wherever possible, consent should be obtained before sharing personal information. In some circumstances, consent may not be obtained, but the safety of the child dictates that the information should be shared. Further guidance is available in the DHSS&PS publication, *The Protection and Use of Patient and Client Information (1999)*

MEDICAL GUIDANCE

8.9 The General Medical Council (GMC) has produced guidance entitled *Confidentiality (1995).* **It emphasises the importance of obtaining a patient's consent to the disclosure of personal information, but makes clear that information may be released to third parties, if necessary without consent, in certain circumstances.** Medical practitioners are advised that:

"If you believe a patient to be victim of neglect or physical or sexual abuse, and unable to give or withhold consent to disclosure, you should usually give this information to an appropriate responsible person or statutory authority, in order to prevent further harm to the patient. In these or similar circumstances, you may release information without the patient's consent, but only if you consider that the patient is unable to give consent, and that disclosure is in the patient's best medical interests".

"Disclosures may be necessary in the public interest where a failure to disclose information may expose the patient, or others, to risk of death or serious harm. In such circumstances you should disclose the information promptly to an appropriate person or authority".

8.10 The GMC has confirmed that its guidance on the disclosure of information which may assist in the prevention or detection of abuse, applies both to information about third parties, for example, adults who may pose a risk of harm to a child, and about children who may be the subject of abuse.

NURSING GUIDANCE

8.11 The Nursing and Midwifery Council (formerly UKCC) produced *Code of Professional Conduct (2002),* which contains the following advice at paragraph 5.3:

"If you are required to disclose information outside the team that will have personal consequences for patients or clients, you must obtain their consent. If the patient or client withholds consent, or if consent canno t be obtained for whatever reason, disclosures may be made only where:

- they can be justified in the public interest (usually where disclosure is essential to protect the patient or client or someone else from the risk of significant harm);
- they are required by law or by order of a court;
- where there is an issue of child protection, you must act at all times in accordance with national and local policies."

SOCIAL WORK GUIDANCE

8.12 *A Code of Ethics for Social W ork* adopted by the British Association of Social Workers (BASW) in 2002 states as a principle of practice:

"They (social workers) will respect service users' rights to a relationship of trust, to privacy, reliability and confidentiality and to the responsible use of information obtained from or about them; Observe the principle that information given for one purpose may not be used for a dif ferent purpose without the permission of the informant; Consult service users about their preferences in respect of the use of information relating to them; Divulge confidential information only with the consent of the service user or informant, except where there is clear evidence of serious risk to the service user, worker, other persons or the community, or in other circu mstances judged exceptional on the basis of professional consideration a nd consultation, limiting any such breach of confidence to the needs of the situation at the time; Of fer counselling as appropriate through out the process of a service user's access to records; Ensure, so far as it is in their power, that records, whether manual or electronic, are stored securely , are protected from unauthorised access, and are not transferred, manually or electronically, to locations where access may not be satisfactorily controlled; Record information impartially and accurately, recording only relevant matters and specifying the source of information. The sharing of records across agencies and professions, and within a multi-purpose age ncy, is subject to ethical requirements in respect of privacy and confidentiality . Service users have a right of access to all information recorded about them, subject only to the preservation of other persons' rights to privacy and confid entiality.

DISCLOSURE OF INFORMATION ABOUT SEX OFFENDERS

8.13 The NIO has produced guidance[6] on the exchange of information about all those who have been convicted of, cautioned for, or otherwise dealt with by the courts for a sexual of fence; and those who are considered by the relevant

6 *'Guidance on the Processes for the Assessment and Management of Risk of Sex Of fenders and Offenders against Children.' (NIO 2001)*

agencies to present a risk to children and others. The guidance also deals with issues about people who have not been convicted or cautioned for offences, but who are suspected of involvement in criminal sexual activity.

8.14 The guidance emphasises that the disclosure of information must take place within an established system and procedure between agencies, and must be integrated into a risk assessment and management system. The police and other relevant agencies should judge each case on its merits, taking account of the degree of risk. The guidance places on the police the responsibility to co-ordinate and lead the risk assessment and management process. It advises that agencies should work within carefully worked out information sharing protocols, and refers to good practice material in existence. It also advocates the establishment of multi-agency risk panels whose purpose is to share information about offenders and to devise strategies to manage their risk. When the alleged or convicted abuser is a child, the information sharing should be managed within the child protection context.

RECORD RETENTION AND DESTRUCTION

8.15 It is the responsibility of staff from individual agencies to maintain their own records of work with child protection cases. Records include those pertaining to the Child Protection Register, child protection case conferences, child abuse investigations, investigations into alleged abuse by professionals. The confidentiality and security of records must be a primary consideration at all times and there must be arrangements in place to facilitate client access. **ACPC procedures must clearly state what happens with any records associated with any part of the child protection process.** Each agency must have a record retention/destruction policy in place which clearly indicates:

- 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.

8.16 The principles of the Data Protection Act (1998) should be adhered to at all times. A brief outline of the principles is given below. When ACPCs, Trusts and individuals are making decisions about the retention of child protection information, it is worth bearing in mind that the 1998 Act distinguishes between ordinary personal data such as name, address and telephone number and sensitive personal data and that the processing of such data is subject to much stricter conditions.

THE DATA PROTECTION PRINCIPLES

8.17 The eight principles of the Data Protection Act (1998) are:

1. Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless:
   - at least one of the conditions in Schedule 2 of the 1998 Act is met; and
   - in the case of sensitive personal data, at least one of the conditions in Schedule 3 of the 1998 Act is also met.

2. Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner inco mpatible with that purpose or those purposes.
3. Personal data shall be adequate, relevant, and not excessive in relation to the purpose or purposes for which they are processed.
4. Personal data shall be accurate and, where necessary, kept up to date.
5. Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
6. Personal data shall be processed in accordance with the rights of data subjects under this Act.
7. Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and agains t accidental loss or destruction of, or damage to, personal data.
8. Personal data shall not be transferred to a country or territory outside the EEA (European Economic Area) unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Staffing Issues

9

RECRUITMENT AND SELECTION OF STAFF

9.1 All agencies and organisations whose 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 closely with children. Guidance is available from a number sources which include *Making the Right Choice (DHSSPS, 2001), Our Duty to Care (Volunteer Development Agency 2000), Choosing with Care (the Warner Report HMSO 1992), Code of Practice for the Employment of Residential Care Workers (Support Force for Children's Residential Care 1995),* and *Circular HSS (Gen 1) 2/1999 (Children's Safeguards Review: Choosing with Care).* It is expected that as a minimum the following checks must be carried out:

- criminal record checks;
- checking with the DHSSPS Pre-employment Consultancy Service (PECS);
- checking relevant professional registers;
- requiring candidates to prove their identity;
- verifying the authenticity of qualifications;
- taking up references and making personal contact with referees;
- seeking a full employment history for applicants and reserving the right to approach any previous employer; checking with former employers the reason why employment ended; identifying any gaps or inconsistencies within the record of employment;
- making appointments only after references are obtained and checked; and
- making all appointments to work with children (including internal transfers) subject to a probationary period.

9.2 Interviewers should be prepared to ask searching questions to establish the suitability of candidates to work with children.

9.3 Even the most careful selection process cannot identify all those who may subsequently pose a risk to children. Managers should always be alert to indicators of inappropriate behaviour.

SUPERVISION AND SUPPORT

9.4 Child protection work involves making difficult judgements. It is demanding work that is stressful. All those involved must have access to supervision and support from managers on a frequent and regular basis. Senior managers should ensure that line-managers and practitioners fully understand their roles, responsibilities and the limits of their professional discretion and authority.

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;
- help to ensure that practice is soundly based and consistent with ACPC procedures; and
- identify the individual's training and development needs and develop training plans to meet those needs.

9.5 Supervision must be recorded contemporaneously, countersigned, dated by both the supervisor and supervisee and must include:

- an agenda for the session;
- the issues discussed;
- decisions made about individual cases and practice;
- the direction given and timescales for agreed actions.

Case Management Reviews

10

INTRODUCTION

10.1 When a child dies, and abuse or neglect are known or suspected to be a factor in the death, HSS Trusts need to take steps to ensure that all other children who may be at risk of harm are safeguarded (e.g. other children of an alleged perpetrator or other children in an institution wher e abuse is alleged). This should be done in accordance with ACPC procedure s.

10.2 The Trust must immediately inform the Director of Social Services in the HSS Board and the Chair of the ACPC who in turn will inform the Dep artment.

10.3 Any agency, professional or the Department/SSI may refer a case to the Chair of the ACPC if it is believed that there are important lessons for inter - agency working to be learned from a particular case.

10.4 It is important that Case Management Reviews are completed as soon as is practicable and that each agency involved with the case gives the review process the priority it deserves.

WHEN SHOULD AN ACPC UNDERTAKE A CASE MANAGEMENT REVIEW?

10.5 An ACPC should **always undertake** a Case Management Review when:

- a child dies, including death by suicide, and abuse or neglec t is known or suspected to be a factor in the child' s death.

10.6 An ACPC should **always consider** whether to undertake a Case Management review where:

- a child has sustained a potentially life-threatening injury t hrough abuse (including sexual abuse) or neglect;
- a child has sustained serious and permanent impairment of hea lth 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.

10.7 Where more than one ACPC has knowledge of a child, the ACPC for the area in which the child is/was normally resident should take th e lead responsibility for conducting any review. Any other ACPCs that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the review and agreeing the review Act ion Plan (see paragraph 10.32). In the case of looked after children, the ACPC from the area responsible for the child should exercise lead responsibility for conducting any review, again involving other ACPCs with an inte rest or involvement.

10.8 The following questions may help in deciding whether or not a c ase should be subject to a Case Management Review in circumstances other than when a child dies. A 'yes' answer to any of these questions is likely to indicate that a review may yield useful lessons:

- was there clear evidence of a risk of significant harm to a c hild, which was:
  - not recognised by agencies or professionals in contact with t he child or perpetrator; *or*

  - not shared with others; *or*
  - not acted upon appropriately?
- was the child abused in an institutional/community setting (e .g. school, nursery, children's home, residential school, family centre, yo uth group/organisation, juvenile justice centre)?
- was the child abused while being looked after by a HSS T rust (i.e. residential/foster care)?
- does one or more agency or professional consider that its con cerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- does the case indicate that there may be failings or omission s in one or more aspects of the local operation of formal child protection procedures, which go beyond the handling of this case?
- was the child's name or a sibling's name on the Child Protect ion Register, or had his/her name been previously on the Child Protection Register?
- does the case appear to have implications for the community , a range of agencies and/or professionals?
- does the case suggest that the ACPC may need to re-examine it s procedures, or that procedures are not being adequately dissemi nated, understood or acted upon?

THE PURPOSE OF REVIEWS

10.9 The purpose of Case Management Reviews is to:

- establish the facts of the case;
- establish whether there are lessons to be learned from the ca se about the way in which professionals and statutory and/or voluntary a gencies work together to safeguard children; and
- identify clearly what those lessons are, how they will be act ed 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.

10.10 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 cri minal courts respectively to determine as appropriate.

THE DECISION TO PROCEED/NOT PROCEED

10.11 It is the **Chair of the ACPC who has ultimate r esponsibility for deciding whether or not to conduct a Case Management Review .** The ACPC Chair must inform the Director of Social Services and the Department immediately of the decision to proceed to Case Management Revie w. In cases where it has been decided not to proceed to a review , the basis for that decision should also be provided. The Chair of ACPC should also confirm with the relevant agencies that the Case Management Review will or will not proceed.

10

PREPARING FOR A CASE MANAGEMENT REVIEW

ESTABLISHING A CASE MANAGEMENT REVIEW PANEL

10.12 The ACPC Chair should establish a Case Management Review Panel (Review Panel) and appoint a Review Panel Chair. Consideration should always be given to appointing an Independent Review Panel Chair. The ACPC Chair should draw up broad terms of reference for the Review Panel.

10.13 The Review Panel must involve, as a minimum, social services, health, education and the police. There is no automatic agency entitlement to be represented on a Review Panel. The membership must have sufficient seniority and professional child care expertise. The balance of representation must be such that the Review Panel can achieve impartiality, openness, independence, and thoroughness in the review of the case. To assist in achieving independence, it will be useful to draw on the expertise within other ACPCs. The individuals who become members of the Review Panel must not have had any line management responsibility for the specific case under consideration. The Review Panel must include members who are independent of HSS Trusts and other agencies concerned.

AGREEMENTS WITH INVOLVED AGENCIES/PROFESSIONALS

10.14 The Chair of the ACPC should agree with the Chief Executive of each of the involved agencies or involved independent professionals the following:

- the nomination of a representative for the Case Management Review Panel;
- the means of securing individual agency records for the duration of the Case Management Review process and how these can be accessed by the Case Management Review Panel;
- the nomination of one or more liaison officers. The liaison officer's role is to ensure that the Review Panel is given access to any staff, policies, procedures, records or information which it requests;
- the arrangements for carrying out an individual agency/professional review;
- the arrangements for obtaining and validating the completed individual agency/professional review report;
- how the information provided will be included in the Case Management Review report.

Where an involved agency or professional is not agreeing to commit to the Case Management Review process, the Chair of the ACPC should bring this to the attention of the Department of Health, Social Services and Public Safety to have the matter resolved so that the process can continue.

SECURING RECORDS

10.15 Immediately upon the death of a child known to social services, or once it is known that a case is being considered for review, each involved agency should immediately secure its records relating to the case to guard against contamination, loss or interference until the Case Management Review process is complete. Where access to secured records is required by a member of staff involved in the case from any individual agency it should only occur under the supervision of an independent senior member of staff. Such access must be recorded and signed and dated by all those involved.

DETERMINING THE SCOPE OF A CASE MANAGEMENT REVIEW

10.16 The Chair of the ACPC should agree the scope of the review and the terms of reference with the Review Panel. Relevant issues to consider should include:

- what appear to be the most important issues to address to identify learning from this specific case?
- how can the relevant information best be obtained and analysed?
- the need to bring in an outside expert at any stage, to shed light on crucial aspects of the case;
- over what time period should events be reviewed, i.e. how far back should enquiries cover, and what is the cut-off point? What family history/background information will help to better understand the recent past and present which the review should try to capture?
- which agencies and professionals should contribute to the review, and who else (e.g. playgroup leader, community/youth group leader, Chair of a Board of Governors) should be asked to submit reports or otherwise contribute?
- should family members or concerned individuals, who may have referred the case to social services, be invited to contribute to the review?
- will the case give rise to other parallel investigations of practice, for example, a mental health homicide or suicide enquiry, and if so, how can a co-ordinated review process best address all the relevant questions which need to be asked, in the most efficient and effective way?
- is there a need to involve agencies/professionals from other ACPCs' areas (see 10.7 above) and what are the respective roles and responsibilities of the different ACPCs with an interest?
- how will the review process take account of a Coroner's enquiry, and (if relevant) any criminal investigations or proceedings related to the case? Is there a need to liaise with the Coroner and/or the Director of Public Prosecutions?
- who will make the link with relevant interests outside the main statutory agencies, e.g. independent professionals, independent schools, voluntary organisations?
- what is the timescale for the completion of the review?
- how should any public, family and media interest be handled, before, during and after the review?
- does the ACPC need to obtain independent legal advice about any aspect of the proposed review?

10.17 Some of these issues may need to be re-visited as the review progresses, or as new information emerges.

TIMING

10.18 Case Management Reviews will vary widely in their breadth and complexity, but in all cases lessons learned should be acted upon quickly. Within **one month** of a case coming to the attention of the Chair of the ACPC the decision should be made on whether to proceed with a Case Management Review, the Case Management Review Panel established, files secured and agreements with Chief Executives of individual agencies reached. By the end of the **second month** the ACPC Chair and the Review Panel should have scoped the review and agreed terms of reference and the action plan. The ACPC Chair should immediately share the agreed terms of reference and action plan with the Department and involved agencies.

10.19 Case Management Reviews should be completed within **five months** of the decision of the Chair of the ACPC to initiate it. As soon as it emerges that a review cannot be completed within **five months,** there should be a discussion with the Department to outline the reasons for the delay and to agree a timescale for completion.

10.20 In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the ACPC should discuss with the relevant criminal justice agencies how the review process should take account of such proceedings, e.g. how does this affect timing, the way in which the review is conducted (including interviews with relevant personnel), and who should contribute and at what stage? Case reviews should not be delayed because of outstanding criminal proceedings, or an outstanding decision on whether or not to prosecute. An understanding of and learning from a particular case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases, it may not be possible to complete, or to publish, a Case Management Review until after the Coroner's or criminal proceedings have been concluded, but this should not prevent early lessons being learned or acted upon.

INDIVIDUAL AGENCY REVIEWS

10.21 The initial scoping of the Case Management Review will have identified those who should contribute to the Case Management Review process. However, as the process continues, it may emerge that the involvement of others would be useful. In particular, information may become available through criminal proceedings, which may be of relevance to the review.

10.22 Involved agencies should undertake an Individual Agency Review of the agency's involvement with the child and family. The Chief Executive of each agency involved should appoint a senior representative, who will have the responsibility to conduct the agency's review and using the criteria of impartiality, openness and thoroughness (see paragraph 10.13). The Chair of the ACPC should agree with the Chief Executive the role and responsibilities of this particular individual from the outset. An Individual Agency Review should begin as soon as a decision is taken to proceed with a Case Management Review. Relevant independent professionals (including GPs) should provide reports detailing their involvement with the child and family.

10.23 It is the responsibility of the individual agency's senior representative to ensure that an evaluation of practice is carried out. An agency's senior representative also has an important role in providing guidance on how to balance confidentiality and disclosure issues in relation to child protection matters.

10.24 Where a guardian ad litem contributes to a review, the prior agreement of the courts should be sought so that the guardian's duty of confidentiality under the court rules can be waived to the degree necessary.

10.25 Those involved in conducting Individual Agency Reviews should not have been directly concerned with the child or family, or be the immediate line manager of the practitioner(s) involved.

THE AIM OF INDIVIDUAL AGENCY REVIEWS

10.26 The aim of Individual Agency Reviews is to look objectively and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about.

ENDORSEMENT BY THE AGENCY CHIEF EXECUTIVE

10.27 Individual Agency Review reports should be endorsed by the Chief Executive who has commissioned the report in agreement with the Chair of the ACPC. The Chief Executive is responsible for certifying that the report is factual and thorough and that the recommendations made to the agency in the report will be acted upon.

10.28 Upon completion of the Individual Agency Review report, there should be a process of feedback and debriefing for all staff involved, in advance of completion of the ACPC Case Management Review report. There may also be a need for a follow-up feedback session at a later stage if the ACPC report raises new issues for any agency and its staff members.

10.29 The following outline format should guide the preparation of Individual Agency Reviews. The questions posed provide a checklist, which will be relevant in every situation. Each case may give rise to specific questions or issues which need to be explored. Each review should consider carefully the circumstances of individual cases and how best to structure a review in light of those particular circumstances. Those preparing an Individual Agency Review report should make a written record of interviews with staff or others and this should be shared with the relevant interviewee. The relevant interviewee should sign to indicate that the factual details provided by him/her have been accurately represented in the record and subsequent report. He/she may not, however, change the analysis reached.

10

INDIVIDUAL AGENCY REVIEWS

WHAT WAS THE AGENCY INVOLVEMENT WITH THIS CHILD?

WHAT WAS THE AGENCY INVOLVEMENT WITH THE FAMILY?

Construct a comprehensive chronology of involvement by the agen cy and/or professional(s) in contact with the child and a separate chronology for involvement with the family over the period of time set out in the review's term of reference. Include a summary of the following:

- assessments undertaken, outcomes including decisions reached;
- services offered to the child / services of fered to the family;
- services provided to the child / services provided to the family; levels of service uptake and family/agency perceptions;
- other action taken.

ANALYSIS OF INVOLVEMENT

Consider the events that occurred, the assessment and decisions made, and the actions taken or not taken. Where judgments were made, or a ctions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why . Consider specifically:

- if practitioners were sensitive to the needs of the children i n their work, knowledgeable about potential indicators of child development, abuse or neglect, for example, failure to thrive;
- if practitioners knew what to do if they had concerns about a child or a parent's/carer's capacity to care for the child;
- if the agency had in place policies and procedures for safegua rding children and acting on concerns about their welfare;
- what written records indicate in relation to theoretical concepts, practice wisdom and evidence-based practice;
- the key relevant points/opportunities for assessment and decis ion making in this case in relation to the child and family;
- if actions taken were in accordance with assessments and decisions made at appropriate levels. For example, were appropriate services o ffered or provided or relevant enquiries made in light of assessments?
- if appropriate child protection or care plans were in place an d child protection and/or looked after reviewing processes were complie d with in cases where these are considered relevant;
- when, and in what way, the child(ren)'s wishes and feelings were ascertained and considered and if this information was recorded ;
- if practice was sensitive to the racial, cultural, linguistic and religious identity of the child and family;
- if senior managers, or other agencies and professionals were involved at points where they needed to be;
- if the work in this case was consistent with the agency' s and ACPC policy and procedures for safeguarding children and wider professional standards.

WHAT HAS BEEN LEARNED FROM THIS CASE?

- Are there lessons from this case for the way in which this agency works to safeguard children and promote their welfare?
- Is there good practice to highlight as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnerships with other agencies?
- Are there capacity and resource issues?

RECOMMENDATIONS FOR ACTION

What action should be taken by whom and by when? What outcomes should these actions bring about and how will the agency review how they have been achieved?

DISCIPLINARY ACTION

10.30 It is important to remember that the Individual Agency Reviews / Case Management Reviews are not a part of any disciplinary enquiry or process, but information that emerges in the course of a review may indicate that disciplinary action should be taken under established procedures. In some cases (e.g. alleged institutional abuse) disciplinary action may be needed urgently to safeguard other children. Therefore, Individual Agency Reviews/ Case Management Reviews may be conducted concurrently with disciplinary action.

THE ACPC'S CASE MANAGEMENT REVIEW REPORT

10.31 The ACPC's Case Management Review Report should bring together and relate the information and analysis contained in the Individual Agency Reviews, together with reports commissioned from any other sources or relevant interests. The ACPC's report should be produced according to the following outline format although, as with Individual Agency Reviews, the precise format will depend upon the features of each case.

ACPC'S CASE MANAGEMENT REVIEW REPORT

INTRODUCTION

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to the review and the nature of their contributions (e.g. Individual Agency Review by HSS Trust, report from family general practitioner).
- List review panel members, chair and author of Case Management Review Report.

THE FACTS

- Prepare a genogram showing membership of family, extended family and household.
- Prepare an ecomap showing the inter-agency/professional/community involvement with the family, extended family and household.
- Compile a chronology of involvement with the child and a separate chronology of involvement with the family which shows the integrated involvement of all relevant agencies, professionals and others.
- Note specifically in the chronology each occasion on which the child was seen and the child's views and wishes sought or expressed.
- Prepare an overview which summarises what relevant information was known to each involved agency and professional about the parents/carers, any perpetrator, and the home circumstances of the specific child and other children and family members. Include additional information purposefully sought by those conducting the review to, for example, substantiate unanswered claims or to clarify a situation.

ANALYSIS

This part of the Case Management Review Report should look at how and why events occurred, the basis for decisions, who made the decisions, the actions taken, the timeliness and appropriateness of actions taken and how all of this is reflected in case records. This is the part of the report in which reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events or outcome for the child. The analysis section is also where examples of good practice should be highlighted and commented upon.

CONCLUSIONS AND RECOMMENDATIONS

This part of the report should summarise what, in the opinion of the Review Panel, are the lessons to be drawn from the case and how these lessons should be translated into recommendations for action. Recommendations should include, but should not be limited to, the recommendations made in the individual reports of involved agencies. Recommendations should, where possible, be few in number, focused and specific and capable of being implemented. If there are lessons for regional as well as local policy and practice, these should be highlighted.

ACPC ACTION ON RECEIVING REPORTS

10.32 On receiving a Case Management Review Report the ACPC Chair should:

- ensure that contributing agencies and individuals have endorsed and agreed that the information provided is fully and fairly represented in the Case Management Review Report;

- convene a special meeting of the ACPC (where more than one ACPC is involved then representation at this meeting should be as agreed at the outset of the process);

- in conjunction with the ACPC translate recommendations into an Action Plan which should be endorsed and adopted at a senior level by each of the agencies involved. The plan should set out who will do what , by when, and with what intended outcome. The plan should set out b y what means improvements in practice/systems will be monitored a nd reviewed;

- clarify to whom and when the report, or any part of it, should be made available;

- disseminate the report, or its key findings, to interested parties as agreed;

- make arrangements to provide feedback and de-briefing to staf f, family members of the child whose case has been reviewed and the media as appropriate; and

- provide a copy of the Case Management Review Report, Executive Summary, Action Plan and Individual Agency Reports to the Depar tment.

10.33 There **must** be clarity about the interface between the dif ferent processes of investigation (including criminal investigations); ***case management,*** including help for abused children and immediate measures to en sure that other children are safe; and ***review,*** i.e. learning lessons from the case to lessen the likelihood of such events happening again. The processes while different should inform each other. Any proposals for review should be agreed with those leading any criminal investigation to make sure that the review does not prejudice possible criminal proceedings.

ACCOUNTABILITY AND DISCLOSURE

10.34 ACPCs should consider carefully who might have an interest in the review' s outcome e.g. Board Members of HSS Trusts, Boards or other involved agencies, staff, members of the child's family, the public, the media – and what information should be made available to each of these stak eholders. There are difficult issues to balance which include:

- the need to maintain confidentiality in respect of personal in formation contained within the reports on the child, family members and o thers;

- the accountability of public services and the importance of ma intaining public confidence in the process of internal review;

- the need to secure full and open participation from the dif ferent agencies and professionals involved;

- the responsibility to provide relevant information to those with a legitimate interest; *and*

- constraints on sharing information when criminal proceedings a re outstanding, in that access to the contents of information may not be within the control of the ACPC.

10.35 It is important to anticipate requests for information and to plan in advance how and when they should be met. For example, a lead agency may take responsibility for de-briefing family members, or for responding to media interest about the case, in liaison with other involved agencies and professionals. In all cases, the ACPC Case Management Review Report should contain an Executive Summary which can be publicised and which includes, as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made. Before the Executive Summary is released into the public domain, related court proceedings should have concluded. The content of the Executive Summary will need to be suitably anonymised in order to protect the confidentiality of relevant family members and others.

LEARNING LESSONS LOCALLY

10.36 Case Management Reviews are of little value unless lessons are learned from them. At least as much effort should be spent on acting on recommendations as on conducting the review. The following may help to maximise the benefits of the review process:

- as far as possible, conduct the Case Management Review so that the process is a learning exercise in itself, rather than a trial or ordeal;
- consider what information needs to be disseminated, how and to whom, in the light of the Case Management Review. Be prepared to communicate examples of both good practice and areas where change is required;
- focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended future outcomes;
- the ACPC should put in place a means of auditing action against recommendations and intended outcomes;
- seek feedback on Case Management Review reports from the Department and SSI which should use reports to inform inspections, performance management and the development of policy.

10.37 Day to day good practice can help ensure that Case Management Reviews are conducted successfully and in a way most likely to maximise learning. Examples of good practice include:

- developing good communication and mutual understanding between disciplines and members of the ACPC;
- establishing a culture of self-evaluation, audit and review so that tragedies are not the only reason inter-agency work is reviewed;
- having in place clear, systematic case recording and record keeping systems;
- communicating with the local community and media to raise awareness of the positive work of the statutory services with children, to avoid disproportionate focus on tragedies;

- making sure staff and their representatives understand what can be expected in the event of a child death/case review.

LEARNING LESSONS REGIONALLY

10.38 Taken together, Case Management Reviews are an important source of information to inform policy and practice regionally. The Department is responsible for identifying and disseminating common themes and trends which emerge across ACPCs' Case Management Review Reports, and acting on lessons for policy and practice developments. The Department will commission Regional Case Management Overview Reports. These will be published at intervals, which the Department considers will maximise learning.

FURTHER ACTION BY ACPC

10.39 Paragraph 10.32 above makes reference to the need for ACPCs to put auditing arrangements in place to monitor action against recommendations and intended outcomes. ACPC should produce a short report approximately one year after the Case Management Review Action Plan has been put in place. The report should be forwarded to the Department and provide an update which demonstrates that recommendations have been acted upon and the degree to which the stated intended outcomes have been achieved. Where progress cannot be demonstrated, the report should offer an explanation and outline any further action which the ACPC considers necessary.

FURTHER ACTION BY THE DEPARTMENT

10.40 Under Article 152 of the Children Order the Department may instigate local or other inquiries where it appears advisable to do so. This can include an inquiry into the functions of a HSS Trust or voluntary organisation which relate to children. An inquiry of this kind would be quite distinct from a Case Management Review. However, it is possible that the findings of a Case Management Review could lead to such an inquiry.

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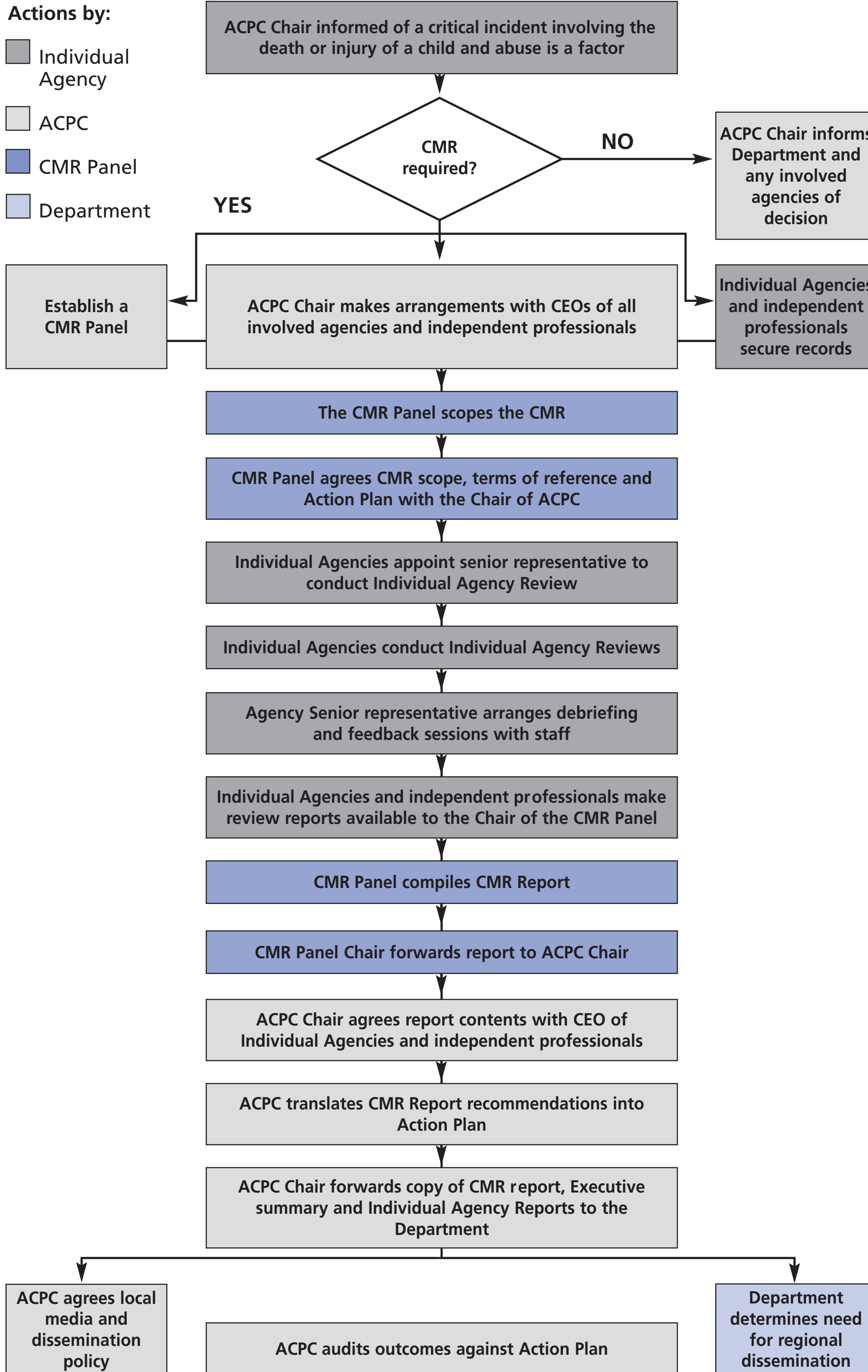

Inter-Agency Training

11

INTRODUCTION

11.1 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, therefore, important that staff in direct contact with children and those in supervisory and management positions receive training on:

- the legislative framework;
- policy and procedures;
- child development;
- assessment and analysis of risk;
- predisposing factors, signs and symptoms of child abuse;
- information sharing; and
- co-operating with other agencies, disciplines and the family to safeguard children.

11.2 Inter-agency training should complement the training available to staff in single agency or professional settings. It is an effective way of promoting a shared understanding of the respective roles and responsibilities of different professionals leading to more effective working relationships. Senior managers should have mechanisms in place to assess staff training requirements and to ensure that staff at all levels are facilitated to avail of all multi-disciplinary child protection training opportunities as a means of ensuring that competence is commensurate with the tasks expected of them. It is important that skills and knowledge are updated through training so that all those working in the safeguarding arena retain a common understanding of developments in child protection practice.

TARGET AUDIENCE

11.3 Inter-agency training should be targeted at the following groups from voluntary, statutory and independent agencies:

- those who work directly with children including hospital and community doctors and nurses and other allied health practitioners, GPs, hospital and community mental health staff, teachers, education welfare officers, youth workers, social workers, police, probation officers, psychologists, family support workers, juvenile justice workers in both residential and community settings, volunteers, school governors, day care staff etc.;
- those who work in adult services relevant to children's welfare, for example, mental health staff and probation officers;
- those who manage and supervise practitioners in the above groups; and
- those who have a governance, strategic and managerial responsibility for services for children and families.

ROLE OF THE ACPC

11.4 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.

11.5 ACPCs should be strategically involved in all stages of the training. They should:

- ensure that training needs are identified, met and reviewed;
- develop and maintain structures and processes for a co-ordinated approach to inter-agency training e.g. an ACPC training sub-committee; and
- include training as a standard ACPC agenda item to ensure that it is regularly reviewed, taking into account current needs, ACPC strategies, and single and inter-agency training responsibilities.

ROLE OF EMPLOYERS

11.6 Employers have a responsibility to resource and support inter-agency training by:

- providing staff who have the relevant expertise to sit on the training sub-committee and contribute to training;
- allocating the time needed to complete inter-agency training tasks effectively;
- releasing staff to attend the inter-agency training courses and ensuring that staff receive relevant in-house training and opportunities to consolidate learning; and
- contributing to the planning, resourcing, delivery and evaluation of training.

FRAMEWORK FOR TRAINING

11.7 Training should be tailored to meet the needs of different staff. The following framework outlines 3 types of training matched to depth of involvement of the staff concerned:

Stage 1: those in day-to-day contact with children and families including teachers, education welfare officers, psychologists, library staff, youth and community workers, social workers, family centre staff, residential care workers, foster carers, childminders, leisure centre staff, police officers, probation officers and hospital and community doctors and nurses and other allied health practitioners;

Stage 2: those professionals and staff of agencies working with children where there may be a high risk of significant harm, but who are not directly involved in child protection services, e.g. reside ntial social workers, probation officers, health visitors, accident& emergency doctors and nurses, paediatric doctors and nurses;

Stage 3: those directly involved in the investigation, assessment and intervention to protect children considered to be at risk of significant harm, e.g. social workers in childcare programmes and police officers in CARE Units.

STAGE 1 INTRODUCTION TO CO-OPERATING TO SAFEGUARD CHILDREN	STAGE 2 CO-OPERATING TO SAFEGUARD CHILDREN FOUNDATION	STAGE 3 WORKING TOGETHER ON PARTICULAR AREAS OF PRACTICE
Key Outcomes Knowledge of: • Signs and symptoms of child abuse. • Own role and that of others. • Reporting procedures. • Local services available to protect children. • The part they may be asked to play in safeguarding children or in a child protection plan.	**Key Outcomes** Knowledge of: • Stage 1 outcomes. • Tasks they may be allocated to safeguard the child, e.g. contribute to assessments, attend case conferences and contribute to planning. • Collaborative working. • Developing working relationships with other professionals.	**Key Outcomes** Knowledge of: • Stages 1 and 2. • Co-working on complex tasks, e.g. joint investigations. • Memorandum of Good Practice for video recorded interviews. • Complex assessments. • Maintaining working partnerships. • Legislation. • Organisational arrangements of all agencies involved.

In addition, managers need appropriate training to enable them to audit and monitor child protection services to ensure that these outcomes are achieved.

11.8 ACPCs should specify the detailed content of training at each stage of the framework. It should reflect the principles, values and processes set out in this guidance. The training should be relevant to the professional groups from the various agencies involved. The programmes should be regularly reviewed and updated in the light of experience.

11.9 ACPCs should have arrangements to ensure the provision of good quality inter-agency training. Some of them have appointed inter-agency training co-ordinators which have proved an effective approach to assessing the need for training, managing its delivery and monitoring its quality.

11.10 They also have a public education role to increase community awareness of child abuse and to enable individuals to play their part in safeguarding children. It can be fulfilled either by staff of member agencies directly providing training to community and voluntary groups or by ACPCs commissioning the services of others.

Appendix 1

Appendix 1

ARMED SERVICES - ARRANGEMENTS FOR CHILD PROTECTION

1. This appendix relates to Service families living in Northern Ir eland which should be included in ACPC procedures.

GENERAL

2. Legislation places the responsibility for the care and protecti on of children on HSS Trusts. Therefore Service authorities should co-operate fully with them and provide relevant information and assistance.

PROCEDURES

Army

3. The Personal Welfare Service (PWS), which consists of qualified Soldiers', Sailors' and Airmens' Families Association (SSAFA Forces Help) Social Workers and Army Welfare Workers (AWW), is responsible for providing a professional social work service to the services community.

4. When a child protection concern comes to the notice of the PWS, its staf f are required to immediately notify the local HSS Trust. Similarly, when a case comes to the attention of the HSS Trust, contact should be made with the relevant PWS Team, whose area of responsibility and telephone numbers are as follows:

Antrim and Ballymena	02894 455557
Lisburn, Holywood and Belfast	02892 266878
Ballykelly and Londonderry	02877 721365
Omagh and Enniskillen	02882 258910
Ballykinler, Armagh and Portadown	02844 610102

5. At the request of the HSS Trust, the SSAFA Forces Help Social Worker and, where appropriate, the AWW/Unit Welfare Officer (UWO) should attend case conferences.

6. The SSAFA Forces Help/PWS Co-ordinator is available on 02892 266008, in an emergency and/or for advice on child protection/welfare policy issues.

Royal Irish Regiment (Home Service)

7. HSS Trusts are also responsible for safeguarding the children of the Royal Irish Regiment (Home Service) families. In case of concern about such children the Regimental Welfare Officer should be contacted at the Regimental Headquarters on 028 2566 1380.

MAHI - STM - 101 - 005744

Royal Navy and Royal Marines

8. The Naval Personal and Family Service (NPFS) provides qualified social workers. Northern Ireland is covered by a team which can be contacted in Helensburgh at 014 3667 2798.

Royal Air Force

9. The Royal Air Force does not have an independent welfare organi sation. Responsibility for families is a function of command co-ordinat ed by each station's Officer Commanding Personnel Management Squadron (OCP MS). When there are concerns about a child of a serving member of the RAF , the HSS Trust should contact the OCPMS on 028 9442 1338, or the Senior Medical Officer on 028 9445 5419. The SSAF A Forces Help Social Worker at RAF Aldergrove should be contacted on 028 9445 5557.

Service Families Moving to and fr om Great Britain – Notification of entries in the Child Protection Register

10. When a Service family, with a child on the register is about to move to Great Britain, the relevant HSS Trust should notify the local authority for the area to which they are moving. All relevant information should be pr ovided.

11. On occasions HSS Trusts may receive information from local authorities in England about children of Service families moving to Northern I reland whose names are on the register. The HSS Trust should convene a case conference inviting the local SSAFA Forces Help Social Worker or AWW/UWO, as appropriate, and a representative of the local authority. If the local authority in Great Britain does not send a representative a comprehensive report should be requested.

Service Families Moving Overseas

12. When a Service family, with a child on the register is about to move overseas, the HSS Trust should forward full information to:

Director of Social Work
SSAFA Forces Help
Central Office
19 Queen Elizabeth Street
London
SE1 2LP

Tel: 0207 4639231

13. This information should be sent to the appropriate SSAF A Forces Help Social Work Service so that British Forces child protection procedures can be instigated.

Service Families Moving to Norther n Ireland from Overseas

14. When a Service family with a child in need of protection moves to Northern Ireland, SSAFA Forces Help should notify the appropriate HSS Trust and supply full information. The PWS Co-ordinator and SSAFA Forces Help Social Worker should be invited to attend the case conference.

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15. Where children of Service families are the subject of a court order which the Overseas SSAFA Forces Help Social Work Service has been supervising on behalf of a local authority, that authority should notify the HSS Trust and provide full information. The local authority may request the HSS Trust to supervise the case on its behalf or transfer the order.

Emergency Action regarding Service Families Abroad

16. Where the Service authority return a family to Northern Ireland from overseas because there are serious concerns about the safety of one or more of the children, the responsibility for child protection rests with the relevant HSS Trust which should consider the need for emergency action. The PWS Co-ordinator should inform the Trust of the circumstances before the family's arrival to enable the Trust to make appropriate arrangements.

17. In Overseas Commands a designated person may make an application for an emergency protection order (EPO) to a Commanding Officer. The grounds for making an order mirror those for EPOs under the Children Act (1989). If, at a case conference, it is decided that it is not in the best interests of the child to return to the family home, the child may be removed to the care of an appropriate HSS Trust in Northern Ireland. Should this occur, the EPO made in the Overseas Command remains in effect for 24 hours following the arrival of the child. During this period the Trust should decide whether to apply to the court for a further EPO. In such cases the Service Authorities are responsible for returning the parents to the UK so that they can be involved with all proceedings and decisions affecting their child.

Enquiries About Children of Ex-Service Families

18. Where a HSS Trust believes that a child subject to current child protection investigation is from an ex-Service family, SSAFA Forces Help may be able to provide useful information. Enquiries should be addressed to:

Director of Social Work,
SSAFA Forces Help,
19 Queen Elizabeth Street,
LONDON
SE1 2LP

Appendix 2

CHILD PROTECTION MANAGEMENT INFORMATION

The Department will provide details of the child protection information required. This will include the information items listed below. In addition, ACPCs should produce an annual business plan on child protection services in their areas. It should highlight the strengths, weaknesses and gaps in the services being provided. Consideration should also be given to including the information listed.

1. Number of children on the Child Protection Register.
2. Number of children on the Child Protection Register by gender, age, physical and mental disabilities, religion, race, culture, language, type of abuse, length of time on register, legal status and marital status of parent.
3. Number of children referred to the Child & Family programme of care.
4. Number of children referred for child protection reasons.
5. Number of families referred for child protection reasons.
6. Number of children referred for child protection reasons where the family was known to social services at the time of the referral.
7. Number of referrals by source (all sources should be recorded - the total number of sources may be higher than the number of referrals).
8. Number of cases where strategy discussions were held.
9. Number of cases investigated.
10. Number of cases investigated under Joint Protocol.
11. Number of initial case conferences.
12. Number of children whose names have been added to the child protection register.
13. Number of registrations by category of registration.
14. Number of review case conferences.
15. Number of children referred for child protection reasons by gender, age, physical and mental disabilities, religion, race, culture, language, previously on register indicator, legal status and marital status of parent.
16. Number of children registered by gender, age, physical and mental disabilities, religion, race, culture, language, type of abuse, length of time on register, legal status and marital status of parent.
17. Number of children who have been abused or re-abused while their names were on the register.
18. Number of children removed from the register.

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19. Number of children whose names have been removed from the register and who have subsequently been abused or re-abused.

20. Number of children re-registered by frequency of re-registration (once, twice … etc.)

21. Number of Case Management Reviews.

22. Number of children referred for the abuse of children or others by gender , age, disability, religion, race, culture, language, previously on register indicator, legal status and marital status of parent.

Information from the record on enquiries to the register

23. Number and source (i.e. agency) of enquiries about children on the register.

24. Number and source (i.e. agency) of enquiries about children not on the register.

Information related to the use of statutory powers on an emergency basis

25. Number of applications for emergency protection orders.

26. Number of applications for emergency protection orders granted.

Appendix 3

CONTACTS IN HEALTH BOARDS IN THE REPUBLIC OF IRELAND

Action to be taken by HSS Trusts

1. When families with children, who are considered by a Trust to be at risk, are thought to have moved to the Republic of Ireland, the following procedures should be followed:

(i) if the location of the family in the Republic is known, the Trust should send a summary of the family history and reason for concern to the Area Child Care Manager of the Health Board in whose area the family is residing;

(ii) if the location of the family is not known, a short summary of the family history and reason for concern should be sent to the Child Care Managers of all the Health Boards.

2. If a Trust becomes aware that a child who is considered to be at risk has moved into its area from the Republic, the Trust should contact the Child Care Manager of the relevant Health Board for details of any involvement the Board has had with the child or his family.

3. A list of names and addresses of the Health Board are as follows:

Area Child Care Manager
Area 1 (Dún Laogaire)
Tivoli Road
Dún Laoghaire
Co Dublin
Tel: 01-2843579
Fax: 01-2808785

Area Child Care Manager
Area 2 (Dublin South-East)
Vergemount Hall
Dublin 6
Tel: 01-2698222
Fax: 01-2830002

Area Child Care Manager
Area 3 (Dublin South Central)
Unit 43 The Malting Business Park
54/55 Marrowbone Lane
Dublin 8
Tel: 01-4544733
Fax: 01-4544827

Area Child Care Manager
Area 4 (Dublin South West)
Old County Road
Health Centre
Crumlin
Dublin 12
Tel: 01-4154700
Fax: 01-4154701

Area Child Care Manager
Area 5 (Dublin West)
Community Services, Dublin West
Cherry Orchard Hospital
Ballyfermot
Dublin 10
Tel: 01-6206092
Fax: 01-6206265

Area Child Care Manager
Area 6 (Dublin North West)
St Josephs School for the Deaf
Social Work Dept
Navan Road
Dublin 7
Tel: 01-8385034
Fax: 01-8385060

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Area Child Care Manager
Area 7 (Dublin North Central)
Rose Cottage, Convent Ave
Off Richmond Road
Fairview
Dublin 3
Tel: 01-8575431
Fax: 01-8575449

Area Child Care Manager
Area 8 (Dublin North)
Coolock Health Centre
Cromcastle Road
Coolock
Dublin 5
Tel: 01-8476122
Fax: 01-8479944

Area Child Care Manager
Area 9 (Kildare)
Poplar House
Poplar Square
Naas Co Kildare
Tel: 045-876001
Fax: 045-879225

Area Child Care Manager
Area 10 (Wicklow)
Glenside Road
Wicklow
Co Wicklow
Tel: 0404-68400
Fax: 0404-69044

Area Child Care Manager
Longford/Westmeath
Health Centre
Longford Road
Mullingar
Tel: 044-40221
Fax: 044-39170

Area Child Care Manager
Laois/Offaly
Health Centre
Arden Road
Tullamore
Co Offaly
Tel: 0506-46254
Fax: 0506-46157

Area Child Care Manager
Limerick
Vocational Training Centre
Dooradoyle
Limerick
Co Limerick
Tel: 061-482792
Fax: 061-482759

Area Child Care Manager
Clare
Tobartaoiscain
Ennis
Co Clare
Tel: 065-6823921
Fax: 065-6823926

Area Child Care Manager
North Tipperary
Annbrook
Limerick Road
Nenagh
Co Tipperary
Tel: 067-38300
Fax: 067-38301

Area Child Care Manager
Cavan/Monaghan
Child Care Department
Local Health Care Unit
Rooskey
Monaghan
Tel: 047-30475
Fax: 047-30796

Area Child Care Manager
Louth Meath
Louth Community Services
Community Care
Dublin Road
Dundalk
Tel: 042-9332287
Fax: 042-9332496

Area Child Care Manager

County Clinic
Navan
Co Meath
Tel: 046-78748
Fax: 046-22818

Appendix 3

Area Child Care Manager
Donegal/Sligo/Leitrim
Shiel House
College Street
Ballyshannon
Co Donegal
Tel: 071-9822776
Fax: 071-9822779

Area Child Care Manager
Waterford
Community Care Centre
Cork Road
Waterford City
Tel: 051-842800
Fax: 051-842811

Area Child Care Manager
South Tipperary
Community Care Centre
Western Road
Clonmel
Co Tipperary
Tel: 052-77285
Fax: 052-25337

Area Child Care Manager
North Lee
Floor 2 Abbeycourt House
George's Quay
Cork
Tel: 021-4923952
Fax: 021-4923953

Area Child Care Manager
West Cork
Hibernian Building
13/14 Main Street
Skibbereen
Co Cork
Tel: 028-40580
Fax: 028-23172

Area Child Care Manager
Galway
Community Care Offices
25 Newcastle Road
Galway
Tel: 091-523122
Fax: 091-524231

Area Child Care Manager
Carlow/Kilkenny
Community Care Centre
James Green
Kilkenny
Tel: 056-52208
Fax: 056-64172

Area Child Care Manager
Wexford
Community Care Centre
George's Street
Wexford
Tel: 053-23522
Fax: 053-21842

Area Child Care Manager
South Lee
Floor 2 Abbeycourt House
George's Quay
Cork
Tel: 021-4923833
Fax: 021-4923953

Area Child Care Manager
North Cork
Gouldshill House
Mallow
Co Cork
Tel: 022-31244
Fax: 022-30211

Area Child Care Manager
Kerry
6 Denny Street
Tralee
Co Kerry
Tel: 066-7184811
Fax: 066-718480

Area Child Care Manager
Mayo
Mayo Community Services
3rd Floor St Mary's Hospital
Castlebar
Co Mayo
Tel: 094-22333
Fax: 094-27106

Appendix 3

Area Child Care Manager
Roscommon
Childcare Office
Abbey Town House
Abbey Street
Roscommon
Tel: 0903-26732
Fax: 0903-26776

Appendix 4

GROUPS OF CHILDREN KNOWN TO BE VULNERABLE

- children living away from home;
- disabled children;
- children where a parent/carer is misusing drugs /alcohol;
- children exploited through prostitution;
- children in whom illness is feigned or induced;
- children who abuse others;
- children from ethnic minorities;
- children who are victims of domestic violence;
- children of parents with a mental illness;
- children of parents with a disability;
- children of under age parents;
- children who have been physically abused;
- children who have been emotionally abused;
- children who have been sexually abused;
- children who have been neglected.

Appendix 5

LIST OF PUBLICATIONS

A Code of Ethics for Social Work – adopted by the British Association of Social Workers in 1986 -available at **www.BASW.co.uk**

Child Protection: Messages from Research - DOH (1995) – available at **www.doh.gov.uk**

Children (Northern Ireland) Order (1995) – available at **www.hmso.gov.uk**

Children Act (1989) – available at **www.hmso.gov.uk**

Children's Services Planning – Guidance (July 1998).

Choosing with Care (the Warner Report (1992)) – HMSO – available at **www.tso.co.uk**

Circular HSS (Gen 1) 2/1999 (Children's Safeguards Review: Choosing with Care) – available at **www.dhsspsni.gov.uk**

Code of Professional Conduct (2002) - Nursing & Midwifery Council

Code of Practice for the Employment of Residential Care Workers - Support Force for Children's Residential Care (1995)

Confidentiality (1995) – GMC

Defence Council Instruction (Joint Service) (DCIJS) – MoD

Family Homes and Domestic Violence (Northern Ireland) Order (1998) – available at **www.hmso.gov.uk**

Framework for the Assessment of Children In Need and their Families – DOH – available at **www.doh.gov.uk/scg/cin.htm**

Grappling with Smoke – Investigating and Managing Organised Child Sexual Abuse – A Good Practice Guide (1998)– Bernard Gallagher (published by NSPCC) – available at **www.nspcc.org.uk**

Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse (April 2002) - Royal College of Paediatrics and the Association of Police Surgeons

Guidance on Professional Practice for Nurses, Midwives and Health Visitors (1995) – DHSSPS – available at **www.dhsspsni.gov.uk**

Guidance on the Processes for the Assessment and Management of Risk of Sex Offenders and Offenders against Children (2001) – NIO – available at **www.nio.gov.uk**

Guidelines for Professional Practice (2000) – United Kingdom Central Council for Nursing, Midwifery and Health Visiting – available at **www.nmc-uk.org**

Human Rights Act (1998) – available at **www.hmso.gov.uk**

MAHI - STM - 101 - 005754

Appendix 5

Inter-Agency Guidance on the Release of Persons Charged or Held in Connection with Schedule 1 Offences Against Children or Young Persons Under the Age of 17 - DHSSPS Circular - HSS 3/96

Making the Right Choice (2001) - DHSSPS available at **www.volunteering-ni.org**

Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings NIO(2000) – available at **www.nio.gov.uk**

Missing from Care (1998) – report by a joint Local Government Association and ACPO working party in England – available at **www.doh.gov.uk**

Multi-agency Procedures for the Assessment and Management of Sex Offenders (1999) – NIO – available at **www.nio.gov.uk**

Northern Ireland Act (1998) – available at **www.hmso.gov.uk**

Our *Duty to Care (2000)* – VDA - available at **www.volunteering-ni.org**

Pastoral Care in Schools – Child Protection (Department of Education Circular 9/99) – available at **www.deni.gov.uk**

Protocol for the Joint Investigation, by Social Workers and Police Officers, of Alleged and Suspected Child Abuse

Safeguarding Children Involved in Prostitution (2000) – DOH - available at **www.doh.gov.uk/scg/qualitycp.htm**

Sudden Infant Deaths: Patterns, Puzzles and Problems (1985) - Golding J, Limerick S, and MacFarlane A.

SUDI Protocol - Coroners Office

The Children's Evidence (Northern Ireland) Order (1995) – **available at www.hmso.gov.uk**

The Data Protection Act (1995) – **available at www.hmso.gov.uk**

The Protection and Use of Patient and Client Information (1999) – DHSSPS – available at **www.dhsspsni.gov.uk**

The Public Interest Disclosure (Northern Ireland) Order (1998) – available at **www.hmso.gov.uk**

The Sex Offender Act (1997) – available at **www.hmso.gov.uk**

The Young Witness Pack (1998) – NSPCC– available at **www.nspcc.org.uk**

United Nations Conventions on Rights of the Child (1990) – available at **www.unhchr.ch**

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Notes

Protocol For

Joint Investigation

of Alleged and Suspected Cases of Abuse of Vulnerable Adults

December 2003

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FOREWORD

In recent years, significant efforts have been made within Health and Social Services and the Police Service to establish procedural and operational arrangements in order to respond effectively to the abuse or exploitation of vulnerable adults. This has involved a considerable degree of interagency liaison in order to develop effective partnership working which will help to prevent abuse and respond appropriately and sensitively when it occurs.

New measures designed to support vulnerable and intimidated witnesses will result in even closer working arrangements between police officers and Health and Social Services staff.

This protocol is an important aspect of these changes in attempting to outline the roles and responsibilities of the respective agencies and providing guidance about joint working arrangements and investigation. It has been developed in partnership between the Police Service of Northern Ireland, DHSS&PS, Health and Social Services Boards and Trusts in Northern Ireland. It is based on the recognition of the need for more coordinated interagency working to ensure that vulnerable adults, who are at risk of abuse, receive protection, support and equitable access to the criminal justice system.

The protocol was underpinned by local research, and has taken cognisance of the most recent guidance issued in Great Britain by the Home Office and Department of Health.[1] [2] This requires agencies to investigate and take action when a vulnerable adult is believed to be at risk of abuse, to develop interagency policies, procedures and joint protocols that draw on good practice.

Although other agencies will be involved in aspects of the investigative process, the PSNI, Trusts and Boards, through their Registration and Inspection Units, have traditionally taken the lead roles in investigating abuse and reporting crimes. The protocol has

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[1] Bailey A (2001) 'Factors influencing police investigation of sexual crimes committed against people who have a learning disability and implications for public policy'. Dphil Thesis. (University of Ulster)

[2] 'No Secrets: Guidance on developing and implementing multi agency policies and procedures to protect vulnerable adults from abuse'. Home Office/DOH 2000.

been designed as a basis for improved inter agency working and will need to be closely monitored, reviewed and revised in the light of experience. It is supported by an ongoing programme of interagency training.

We commend this protocol to all who are involved in this critical and demanding area of work and would like to place on record our thanks to all who contributed to its development.

Leslie Frew
Director of Community Care
DHSS&PS

Judith Gilllespie
Assistant Chief Constable
Criminal Justice Department
PSNI

1 Introduction

1.1 The PSNI, Boards and Trusts are committed to the development of collaborative working which will enhance arrangements for the protection and support of vulnerable individuals and groups. This will include responding to the specific needs of vulnerable and intimidated victims of crime. In 1998 the Home Office published a report prepared by an Interdepartmental Working Group on the treatment of vulnerable victims and witnesses, entitled 'Speaking Up for Justice'.[3] The report recommended that the existing special measures introduced for children, e.g. live CCTV links and video recorded evidence-in-chief, be extended to include vulnerable adults.

1.2 The subsequent enactment of the Criminal Evidence (NI) Order in 1999 made provision for these arrangements, or 'special measures' to be introduced locally. Guidance on the application of special measures can be found in 'Achieving Best Evidence in Criminal Proceedings: Guidance for Intimidated Witnesses, including Children'.[4]

1.3 Although other agencies, statutory and voluntary, may be involved in aspects of the investigative process, the PSNI, Trust and R & I Unit staff have been primarily responsible for the investigation of abuse and the protection of vulnerable adults. This Protocol is designed to ensure staff from these agencies work together in a way that ensures the well-being and rights of vulnerable adults are paramount. It also helps to ensure that people receive equitable access to justice.

1.4 This Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. It is important that Trust, R & I Unit and PSNI staff read this Protocol in conjunction with the Policy and Procedures presently in use within each of the four Health and

[3] 'Speaking up for Justice' - Home Office (1998)

[4] 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children' - Home Office Communication Directorate (2002)

Social Services Boards. Police officers should be mindful of relevant PSNI General Orders. This Protocol extends to suspected crimes in domiciliary, community and hospital care if the victim is a vulnerable adult as defined in Section 2.

2 Definition

Definition of a Vulnerable Adult

2.1 For the purposes of this Protocol the definition of a vulnerable adult has been taken from 'No Secrets'. It therefore applies to adults:

a) who are 18 years old and over; and
b) who are, or may be, in need of community care services by reason of mental or other disability, age or illness and who are, or may be, unable to take care of themselves, or unable to protect themselves against significant harm or exploitation.

2.2 This definition is more inclusive than the definition of vulnerability contained in the Criminal Evidence (NI) Order 1999. It is likely that some cases of alleged or suspected abuse against vulnerable adults will require a joint approach to investigation but will not qualify for the special measures outlined in the Order in relation to accessing the criminal justice system. It should also be borne in mind that the human and civil rights of the individual may have been breached.

2.3 'No Secrets' also offered a brief definition of abuse as being:
'The violation of an individual's human and civil rights by any other person'.
The original DHSS guidance, which was produced in 1996 as a basis for the development of Board and Trust adult protection policies, offered a more detailed definition of abuse as being:
'The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependent, whether they be informal or formal carers, staff or family members or others. It can occur outside such a relationship'.

3 Aims and Objectives

3.1 The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

3.2 The Protocol aims to:

- ensure effective communication and collaboration between Trusts/R & I Unit and PSNI to protect vulnerable adults;
- involve Trusts/R & I Unit and PSNI in determining whether a single agency or a joint agency investigation is required;
- provide a framework for early consultation, cross referral of appropriate cases and joint working arrangements for investigation and interviewing;
- define the roles and responsibilities of PSNI and Trust/R & I Unit staff in the joint investigation;
- minimise the number of interviews conducted with the victim,
- ensure that protective measures are paramount and run in parallel with the criminal inquiry or any other lines of enquiry, such as civil action or disciplinary proceedings.

4 Principles

4.1 The Protocol aims to promote the following principles in protecting vulnerable adults from abuse and the investigation of alleged or suspected crimes:

- the well-being and rights of the vulnerable adult are paramount;
- the processes should minimise distress to the vulnerable adult by maximising co-operation between agencies;
- Adult Protection Procedures must be properly followed;
- mechanisms should be available to resolve differences of opinion amongst staff through appropriate management structures.

5 Rights and Responsibilities

5.1 The Protocol is also committed to ensuring that the rights of vulnerable adults are upheld. These include the right to:

- receive protection for themselves and their property under the law;
- be supported in reporting the circumstances of any abuse;
- have alleged, suspected or confirmed cases of abuse thoroughly investigated as a matter of urgency;
- have options for resolution and the appropriate processes explained to them;
- be supported in making decisions about how they wish to proceed in the event of abuse and to be kept informed of progress;
- have issues of consent and capacity considered;
- be given information in accessible formats on how to protect themselves;
- be given practical help in protecting themselves;
- be supported when deciding whether to pursue a formal complaint;
- be subjected to the minimum degree of disruption;
- receive support on a longer-term basis, following the abuse.

5.2 In order to promote these rights effectively PSNI, Trust and R & I Unit staff must be aware of their responsibilities in this very difficult area of work. If an allegation of abuse does not appear to relate to criminal conduct, there is no statutory duty to report the matter to the Police and the decision about whether or not to investigate should be judged on the 'best interest' test. In the case of non-criminal matters it may not be in the best interests of the vulnerable adult to investigate if the person has specifically indicated a preference for no investigation. However, in reaching this conclusion, it is necessary to take into account the competence of the person making the decision and any other regulatory or personnel arrangements, e.g. disciplinary procedures, referral to NISCC.

5.3 Although all members of society are duty bound to report arrestable offences (those criminal offences which carry five years imprisonment or more), this Protocol requires staff to consider the cross-referral of suspected crimes whether they are arrestable or

not. In general, the Police are authorised to investigate alleged or suspected criminal abuse against the vulnerable adult where this is agreed to be in the best interests of the person. In the majority of cases, in particular where the vulnerable adult is deemed to have capacity, the Police will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the Police. However, there are some exceptions to this eg; where the vulnerable adult is deemed not to have capacity, is subject to undue influence or where others may be at risk. In some circumstances the Police may also intervene to prevent a crime being committed.

5.4 Where criminal abuse may have been committed then, a referral between the agencies should be made and an agreed strategy should be developed which takes account of the wishes of the alleged victim. The PSNI and Trust/R & I Unit should work sensitively in these enquiries and must secure the co-operation and consent of the victim unless there may be issues in relation to capacity and/or the potential for abuse to third parties. After referral between agencies the agreed strategy should take account of the wishes of the alleged victim. When there are concerns, but no real grounds to suspect that an offence may have been committed, there is a duty on Trust or R & I Unit staff to investigate and report any criminal offences or grounds that may emerge.

5.5 When judging whether the individual has capacity to give or withhold consent the policies of the relevant Board should be followed. This should take into account professional opinion as appropriate eg. Psychiatrists, Psychologists, GPs, Nurses, Social Workers.

6.0 Reporting

6.1 This Protocol is designed to be compatible with current Adult Protection Procedures in requiring all staff to report suspected, alleged or confirmed instances of abuse. It is not intended to replace professional judgements made by Trust or R & I Unit staff. It does however make sure that all cases are given appropriate consideration and are not screened out inappropriately. Added safeguards to prevent this include the necessity to report cases, in line with current policies and procedures, to a designated adult protection officer ('designated officer') and to consult, if necessary, with the relevant Police Liaison Officer. Where a crime is suspected or alleged and the vulnerable adult does not wish to make a formal complaint the agencies should consider the following factors:

- The individual's capacity to provide consent to a formal complaint;
- The extent to which other vulnerable persons, including children, are likely to be at risk;
- The vulnerable adult is subject to undue influence or coercion.

6.2 A referral to the PSNI does not automatically mean that a joint investigation will be initiated. This may involve seeking the views of the Police Liaison Officer. Where the PSNI is informed of suspected abuse which is clearly non-criminal the individual should be made aware of other sources of support and options to have the matter resolved and his/her agreement should be sought to refer to Trust or R & I Unit.

6.3 Alleged or suspected instances of abuse occurring in residential or nursing facilities must be reported to the local R & I Unit, which has a statutory duty to make sure an investigation is undertaken.

6.4 Reports of alleged or suspected abuse, which may be a criminal offence, will be categorised as:

(a) Sexual (e.g. rape, indecent assault)
(b) Non-sexual (e.g. physical assault, theft).

The PSNI will be responsible for determining the category of offence.

6.5 Where alleged or suspected crimes are reported to the PSNI they have a duty to conduct criminal investigations. The decision to investigate will be made at a Strategy Discussion and will be informed by the views of the victim, Trust or R & I Unit colleagues.

Referral to Police from Health and Social Service Trusts

6.6 a) In all cases of alleged or suspected criminal abuse the designated officer for the Trust should discuss the case with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby to inform the decision concerning what level of enquiry/investigation is necessary.

b) Alleged or suspected sexual abuse should be reported to the Detective Inspector (CARE) who holds the role of Police Liaison Officer for sexual crimes.

c) Alleged or suspected non-sexual abuse should be reported to the Police District Command Unit (Crime Manager) who holds the role of Police Liaison Officer for non-sexual crimes. The Crime Manager will allocate any investigation to uniform or CID as appropriate.

d) For referral purposes, where more than one form of abuse is alleged or suspected, sexual offences will take precedence and these cases should be referred in the first instance to the Detective Inspector (CARE). The police will then decide if a criminal investigation is required and which branch of the Police should carry out the investigation.

Referral to Trusts by PSNI

6.7 Police officers who encounter vulnerable adults who may have been the subject of abuse, whether criminal or not, should contact the relevant designated officer to establish whether the vulnerable adult is known or should be referred to the Trust.

Referrals Outside Normal Working Hours

6.8 Where concerns are raised in relation to the care or treatment, which may involve criminal abuse, of a vulnerable adult outside normal working hours (9.00 am - 5.00 pm Monday to Friday), these concerns should be referred immediately to the Out of Hours Social Work Co-ordinator. A list of contact points for Co-ordinators can be found in **Appendix A.**

6.9 The Co-ordinator will take whatever action is necessary to ensure the protection of the vulnerable adult. Depending on the scale of the concern this may involve referral to other agencies. The Co-ordinator will make the relevant designated officer for the Trust aware of the referral details and any action taken/required, as a matter of urgency on the first working day following the date of the referral being made.

Alleged or Suspected Criminal Abuse in Residential or Nursing Facilities

6.10 When criminal abuse is alleged or suspected to have occurred in residential or nursing homes and is reported to, or comes to the attention of the R & I Unit, the Unit manager should ensure that the matter is referred to the Police Liaison Officer and to the relevant Trust. (see 6.6). If an incident of suspected or alleged criminal abuse in a home comes to the attention of Trust staff the R & I Unit must be informed by the designated officer as soon as is practicable.

Referrals from PSNI to R & I Units

6.11 Police officers, who encounter a vulnerable adult who is a resident of a residential or nursing home and who may have been subjected to abuse, whether criminal or not, should contact the manager of the R & I Unit. This will enable them to establish whether the Unit can investigate the matter or whether referral needs to be made directly to the local Trust. Where the need for the R & I Unit to initiate an investigation is indicated the relevant Board/Trust/R & I Unit procedures must be followed.

Inappropriate Referrals

6.12 In any event where a referral is made inappropriately between agencies the receiving agency will have responsibility for referring the matter to the appropriate agency.

7 Initial Assessment – Consultation – Planning and Investigation

Clarification of Roles

7.1 The PSNI, Trust and R & I Unit staff have specialist and complementary skills in terms of assessing and investigating allegations of abuse of vulnerable adults. The process is outlined in **Figure 1**. In appropriate cases it is necessary to combine these skills to provide maximum protection and support for those individuals who have been the subject of, or are at risk of, harm. This Protocol recognises that the various agencies may have different priorities or emphases in relation to adult protection work.

7.2 It is not designed to make Trust, R & I Unit or PSNI personnel undertake roles which are at variance with their primary professional responsibilities. It is however intended to provide a basis for maximising co-operation and a shared understanding of the issues involved. Differences of opinion, or approach, amongst staff should be resolved in a manner that does not hinder the protection of the vulnerable adult. Protection of the individual is paramount and staff should not inappropriately screen out cases by failure to follow this Protocol.

7.3 The strategy to be adopted must be informed by the professional views of PSNI, Trust and R & I Unit staff. The strategy for investigation should always be influenced by information gained from professionals or other persons who may have knowledge of the vulnerable adult, his/her family or circumstances.

7.4 The primary objective of PSNI, Trust and R & I Unit is the protection of the vulnerable adult. In addressing this shared objective the primary role of PSNI personnel is determined by their statutory responsibility to protect life and property, preserve order, prevent crime and, where a criminal offence has been committed, bring offenders to justice.

7.5 The primary role of Trust and R & I Unit staff is determined by their statutory responsibility and Duty of Care, to promote the care and well-being of vulnerable adults in situations of alleged or confirmed abuse.

7.6 Assaults (including minor assaults), thefts, criminal damage, sexual assaults and threats of force or violence are all likely to be criminal offences. PSNI, Trust and R & I staff must recognise that the non co-operation of the victim does not always preclude a prosecution. However, the views of the victim are vital elements in the decision to prosecute.

Joint Agency Consultation

7.7 When either Trust/R & I Unit or PSNI personnel identify the need for a Joint Agency approach, a staff member from the referring agency will take responsibility for instigating a Joint Agency Consultation. The designated officer will take responsibility for co-ordinating the practical arrangements associated with this action. This should be the person within the Trust/R & I Unit deemed to be responsible for the decision to proceed under the Adult Protection Procedures, in cases of alleged or confirmed abuse.

7.8 The purpose of the consultation is to discuss the case with the other agencies and to reach a decision on the need for a Joint Investigation involving Trust/R & I Unit and PSNI. This communication may be by telephone or direct contact and should occur within 24 hours of the decision that consultation with the other agency is necessary.

7.9 The outcome of this consultation may be:

- No further action.
- A Trust/R&I Unit single agency investigation.
- A Criminal Investigation by Police.
- A Joint Investigation involving Trust/R&I Unit and Police.

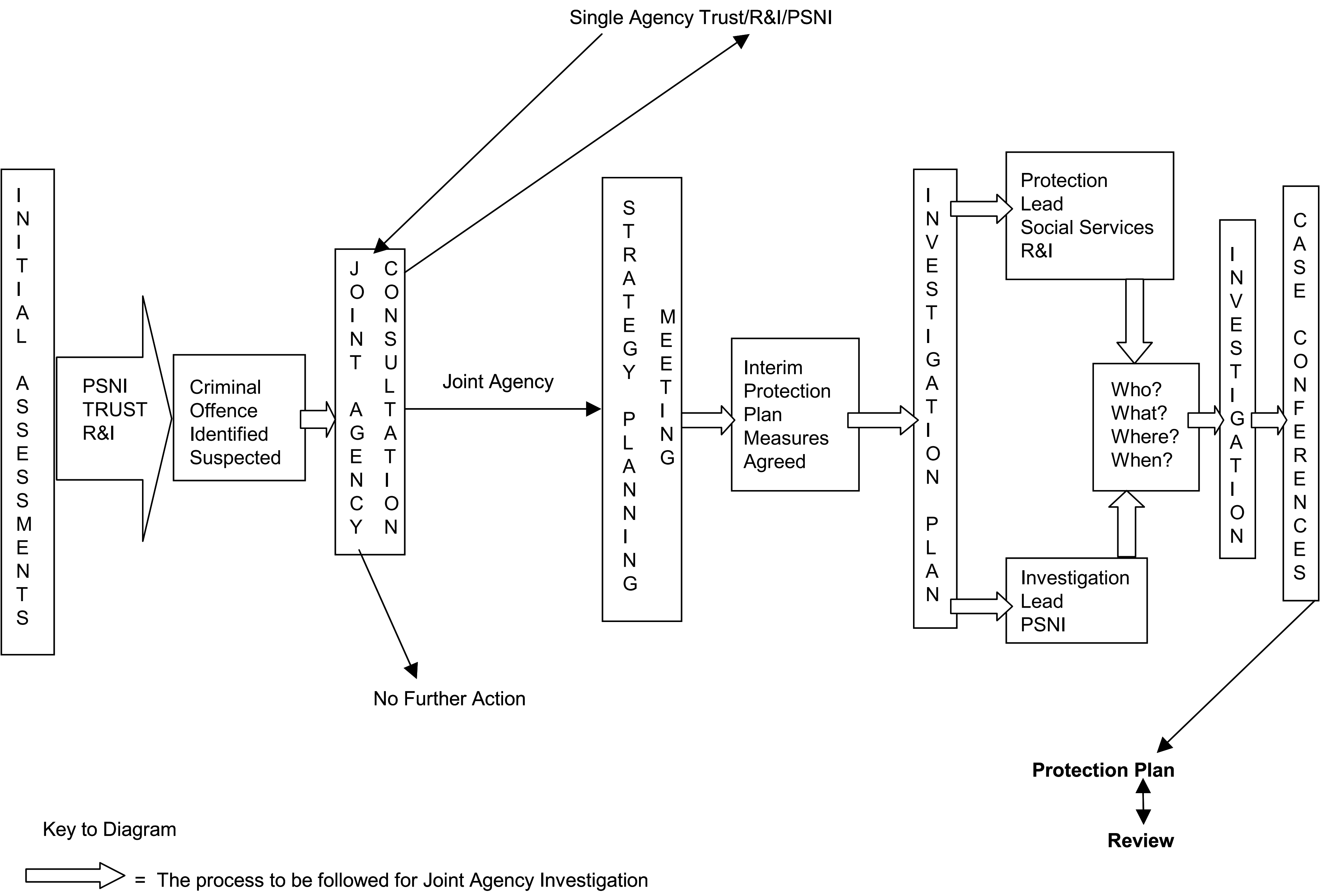
The results of this consultation must be clearly recorded and shared between agencies. **(Appendix B).** Where it is agreed that a Trust/R & I Unit single agency investigation is appropriate, the procedures for the Protection of Vulnerable Adults will be followed.

Criteria for Joint Investigation by Trust/R & I Unit and PSNI

7.10 A detailed consideration of the need for a joint investigation will be triggered when there is an allegation or suspicion that one of the criminal offences described below has been committed against a vulnerable adult. The likelihood or otherwise of a prosecution is not a criterion for a joint investigation.

- **A sexual offence committed against a vulnerable adult.**
- **Physical abuse or ill treatment amounting to a criminal offence.**
- **Financial abuse involving a criminal offence, e.g. fraud, theft.**
- **Abuse which involves a criminal offence e.g. blackmail.**

Figure 1



Preliminary Information Gathering

7.11 Following the decision of the Joint Agency consultation, to initiate a Joint Investigation, each agency will nominate a staff member to gather information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will carry out checks on internal systems for information that may be of use in deciding the strategy to be employed.

Strategy Planning Meeting

7.12 When sufficient preliminary information is available to facilitate the development of a strategy for dealing with the case, a Strategy Planning Meeting should be convened. This should occur as soon as is practicable. The responsibility for convening this meeting lies with the designated staff member who initiated the Joint Agency Consultation.

7.13 The purpose of the Strategy Planning Meeting is to ensure an early exchange of information and to clarify what action needs to be taken jointly or separately in the investigation. It is an action orientated discussion, which should be convened to plan the investigation and agree any necessary interim protection measures.

7.14 A Strategy Planning Meeting will always include Police and Trust and/or R & I staff where appropriate. Other professionals, agency representatives and persons with specialist knowledge/skills may also be included to ensure the protection of the vulnerable adult.

7.15 Where the Strategy Planning Meeting concludes that a vulnerable adult has been the victim of criminal abuse or may be at risk of a serious criminal abuse and that issues arise about the protection of the individual, the Strategy Planning Meeting should address the following points:

- whether action is needed to protect the vulnerable adult and who will be responsible for such action;
- the need to consider the issue of capacity to consent and the most appropriate person to deal with it;
- the requirement for a medical examination to be undertaken and if so, by whom;

- what issues of special needs, race, culture, gender, or religion are raised in the case, how and by whom they are to be addressed and what advice needs to be sought;
- what specialist support or advice might be needed and who will obtain it;
- what other information is needed to complete the investigation and who will seek it;
- the order in which the interviews will take place and who will carry out the interview; and
- practical arrangements for reporting back to those involved in the investigation.

7.16 It is the responsibility of the person who convenes the meeting to ensure that a record of the Strategy Planning Meeting is made and shared between agencies. **(Appendix C).** Although strategy planning will generally take place in a formally constituted meeting there may be occasions where this may need to be conducted by telephone.

8 Joint Investigation Interviews

8.1 Interviews with vulnerable adults will be conducted in accordance with the guidelines contained in 'Achieving Best Evidence in Criminal Proceedings'.

Joint Interviews by Police Officers and Social Workers

8.2 Where it is agreed in the Strategy Planning Meeting that interviews should be conducted jointly by a police officer and social worker the following procedures will apply. It must be emphasised that the decision about which interviews should be conducted jointly, and the sequence of interviews, is a matter for the group planning the investigation at the Strategy Planning Meeting. These procedures should be applied accordingly and the involvement of the R & I Unit should be considered when the alleged abuse has occurred in a nursing or residential home.

Selection of Interviewers

8.3 Only PSNI and Trust personnel, who have received specialist training in Joint Interviewing, should be appointed to the task. Where a vulnerable adult has requested the interviewer to be of a specific gender all reasonable steps must be taken to facilitate this request.

Supervision of Interviewers

8.4 It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

Clarification Discussion

8.5 In making decisions about the method of interviewing vulnerable adults it may be necessary to have a short clarification discussion. This should normally be undertaken by the persons who will conduct any subsequent interview. However where this is not possible the clarification discussion may be carried out by other staff who have received Joint Protocol training. Once a decision has been made that an interview of a vulnerable adult should be conducted on video, a specialist investigative interviewer will be tasked to carry out the interview.

8.6 The purpose of the Clarification Discussion is:

- To establish whether or not the vulnerable adult has made an allegation or raised suspicions which have led to the referral. The substance and detail of the allegation or disclosure should not be part of the Clarification Discussion.
- To assess the vulnerable adult's willingness and ability to pursue the matter to court.
- To inform the police decision about which format should be used for the interview, eg; videotape, statement or question and answer. Videotaping is the preferred method of interviewing vulnerable adults, statements are the alternative and questions and answers should only be used when neither videotaping or statement are possible.
- Whether the use of video in the interview is likely to maximise the quality of that particular vulnerable adult's evidence.

8.7 The Clarification Discussion must be recorded and responsibility for this will lie with the investigator conducting it. The Clarification Discussion is not an investigative interview and should never replace or over-shadow the joint investigative interview with the vulnerable adult. Strictly no further examination of the allegation should take place beyond that which has been disclosed. It is important not to coach the interviewee in respect of the interview. If the discussion includes the disclosure of a criminal offence, that part must be recorded verbatim and contemporaneously, or at the very least as soon as possible after the contact. Even if no criminal disclosure is made, accurate recording is essential as decisions about risk may be made on the strength of the Clarification Discussion. The proforma at **Appendix D** must be completed in respect of every Clarification Discussion.

Preparation for a Joint Interview

8.8 The following should be taken into account when preparing for a Joint Interview:

- The needs and circumstances of the vulnerable adult (eg; development, impairments, degree of trauma experienced, whether he/she is now in a safe environment);
- The vulnerable adult's state of mind (eg; likely distress, and/or shock);
- Perceived fears about intimidation and recrimination;

- The circumstances of the suspected offence (eg; relationship of the individual to the alleged offender);
- Location of interview;
- Time of interview;
- Preferred gender of interviewer; and
- Special requirements.

Purpose of the Joint Interview

8.9 The purposes of the Joint Interview are:

- to promote the well-being and protection of the vulnerable adult;
- to validate or negate allegations or suspicions of abuse by helping the vulnerable adult to give as much information as possible;
- to avoid multiple interviews where possible;
- to identify the suspected abuser;
- to ensure that all decisions are made based on the experience of the vulnerable adult and not the influence or beliefs of the interviewer;
- to provide a record of the vulnerable adult's evidence-in-chief which may be used at a consequent criminal hearing.

Persons Present at Joint Interview

8.10 Normally no one else should be in the interview room apart from the vulnerable adult and the interviewers. Limiting the number of people present at the interview should lessen the possibility of the vulnerable adult feeling overwhelmed by the situation and uncomfortable about revealing information. It is recognised that other persons with specialist skills may be needed to assist the interviewer conduct the interview. This might include, specialist communicators using sign language, etc.

8.11 If it is the vulnerable adult's wish to have a supportive person present in the interview room it should be made clear to that person that he or she must take no part in the interview. It is good practice for the vulnerable adult to know that a supportive person is available in an adjoining room. A suspected offender should never be present in an interview.

Recording Information that is not Video Recorded

8.12 When a Joint Interview with a vulnerable adult is not video recorded a written account of the information given should be

made. If it is assessed by the interviewers, or on the basis of consultation with other expert opinion, that the vulnerable adult is capable of giving an account of relevant matters the PSNI officer may invite the adult to make a signed, written statement on Form 38/36. The evidence of a vulnerable adult who is not capable of making a statement should be recorded as questions and answers and certified by them and any other person present.

The Video Interview

8.13 The Criminal Evidence (NI) Order 1999 provides for the video recording of interviews with vulnerable adults to be admitted as evidence-in-chief at Criminal Proceedings. The guidance accompanying the legislation is designed to help those police officers and any Trust staff involved in making a video recording of an interview with a vulnerable adult, where it is intended that the result should be admissible in Criminal Proceedings.

8.14 The Order is "Permissive" legislation. There should be a general assumption that a video interview will be conducted where the criteria are met (eg an eligible witness in an Indictable [Crown Court] case). Use of a video for all interviews is not necessary in all cases and, on occasions, might add to the interviewee's trauma unnecessarily. The decision as to whether the interview will be videotaped will be taken by the investigating police officer in consultation with Trust staff following the Clarification Discussion.

Planning the Joint Interview

8.15 In order to be fully and properly prepared for an interview the joint investigation team of PSNI and Trust staff should normally plan the interview in line with the 'four phased' approach set out in 'Achieving Best Evidence in Criminal Proceedings' and adhere to the criteria which it has identified. The four phases are:

- **Rapport**
- **Free Narrative**
- **Questioning**
- **Closure**

8.16 Planning should include deciding whether PSNI and Trust team members should take the role of lead interviewer, the proposed time scale, any special arrangements/allowances which are required to take account of the vulnerable adult's individual

difficulties, agreed signals on when to take breaks or terminate the interview. As video recording of investigative interviews is aimed at providing evidence-in-chief at criminal courts, planning must include coverage of the 'points-to-prove' in criminal offences**.**

8.17 Where it appears, before interviewing a vulnerable adult, that the history of the case indicates a considerable amount of information is likely to be forthcoming, a series of interviews may be planned. The second, third, etc. interviews in this series will be considered part of the original interview without any automatic need to consult with the Department of the Director of Public Prosecutions/Public Prosecution Service.

8.18 The joint investigation team must be given sufficient time to carry out this planning process, prior to a joint investigative interview. Failure to allow this time may limit the effectiveness of the process and thereby do a disservice to the vulnerable adult. Preparation for the interview will include the following activities.

Technical Preparation

8.19 The joint investigation team will need to carefully prepare for the interview, ensure that the equipment is in working order, test for vision and sound quality and to ensure that tapes are correctly prepared, checked and inserted. Consideration should also be given to whether other equipment will be needed, e.g. hearing aids, communication boards, etc.

Consultation with Specialists

8.20 The joint investigation team should consider the conclusions of the Clarification Discussion about the need to involve staff with specialist skills in the joint investigative interview and any role they should take in it. Due to the nature of this type of investigative interviewing it will often be necessary to seek specialist assistance with issues such as communication difficulties, mental ill-health or learning disability. If a specialist is asked to facilitate the joint interview, he/she should be informed of the purpose of the interview and the limitations placed on his/her role. He/she should not be asked to undertake the role of "appropriate adult".

8.21 If an interpreter is required to assist in criminal proceedings involving a vulnerable adult who uses sign language the person

must have attained at least Stage 3 British Sign Language or Irish Sign Language qualification.

Consideration of Communicative Competency of Vulnerable Adult and Interviewer

8.22 The vulnerable adult and interviewers need to be able to achieve the minimum requirements for communication. The joint investigation team must establish whether a vulnerable adult has a reliable method of communication which he/she can use intentionally and that the interviewers can understand either directly or via a suitable interpreter.

8.23 If the vulnerable adult has specific difficulties with comprehension or use of language (vocabulary, ideas and grammar) associated with physical or intellectual impairment careful consideration must be given to how these could be overcome. Speech and language therapists, sign language interpreters or facilitators in augmentative communication may be required.

8.24 The competency of the interviewers in communicating will be the single greatest factor in determining whether a vulnerable adult will be able to deal with, and participate effectively in, an interview situation. The interviewer will also require information about the vulnerable adult's knowledge and understanding of him/herself, about objects, about places and events and how these things may be affected by his/her impairment or disability.

Conduct of the interview

8.25 The interviewers need to provide the vulnerable adult with information at a level which will help him/her to understand who and what will be involved. Initially they should cover:

- introduction of the social worker (or other professional) and the police officer with explanation of each of their roles;
- an explanation of the purpose of the interview in a sensitive way that the vulnerable adult can understand;
- an acknowledgement that it is a difficult situation for the vulnerable adult and that some things, particularly sexual assault, may be difficult to talk about;
- introduction of the video equipment and seeking consent to use it in the interview.

8.26 The following are categories of facts, which, if contained in the vulnerable adult's evidence, will enable properly informed decisions to be taken regarding the subsequent conduct of the investigation and ultimately whether or not to prosecute any person for any offence committed against them.

- Name/identity of the alleged abuser/offender, his/her present whereabouts, and the relationship of that individual to the vulnerable adult.
- The duration and extent of the abuse/offence.
- What happened in detail, when it happened, where, and how often, being mindful of the 'points-to-prove' for each offence.
- Date/time of last occurrence, likelihood of physical evidence.
- Names/identity of anyone else having knowledge of the abuse/offence.
- Names of anyone else involved in, or observing the abuse/offence.
- Identity of anyone the vulnerable adult has told about the abuse/offence.

8.27 After the interview, the vulnerable adult and/or their representative should be given as much information as possible about what will happen next including arrangements for his/her protection. If he/she is to be interviewed again, he/she should be informed of where and when it may take place.

8.28 If the interview or series of interviews has been completed and further information comes to light which makes it necessary to conduct another interview with the vulnerable adult, or where it is believed the vulnerable adult has more to tell, this should be considered a further or supplementary interview. In this case the matter should be discussed with the Department of the Director of Public Prosecutions/Public Prosecution Service. This will cover cases where, for example, conflicting evidence comes to light, a vulnerable adult makes further disclosures or names other suspects. 'Achieving Best Evidence' should be referred to when considering the further interview of a vulnerable adult.

8.29 Once the interview is complete, the joint investigation team should give consideration to the individual's need for any counselling or therapeutic requirements which this may have indicated. PSNI and the Department of the Director of Public Prosecutions/Public

Prosecution Service must be informed about the nature of such therapy in each case. This is to ensure that the evidence provided to a Court is not contaminated or contradicted by the vulnerable adult.

The Vulnerable Adult who becomes a Suspect

8.30 If a vulnerable adult becomes suspected of a crime during the course of an interview, a decision will have to be made on whether to proceed or terminate the interview. The interviewers should take a short break to consult, and if necessary seek advice, on the matter, in addition to being mindful of the need for sensitive handling of the situation. If it is concluded that the evidence of the vulnerable adult as a suspect is paramount in a particular case, the interview should be terminated so that any further questioning can be carried out in accordance with the Police and Criminal Evidence (NI) Order 1989, (PACE) at an appropriate location.

Further Interviews

8.31 Occasions may arise where a police officer or a social worker may wish to further interview a vulnerable adult who is the victim of some criminal offence. It will be the responsibility of that police officer or social worker to advise the other agency of the intention to further interview the individual. The same procedures will apply to a further interview as apply to the original interview. No agency should unilaterally conduct further interviews with the vulnerable adult who may be central to criminal proceedings.

Records of Joint Investigative Interviews

8.32 Police will retain a written statement, recorded as a Joint Interview, for evidential purposes. A copy may be provided to Trust and/or R & I Unit staff, provided that the vulnerable adult agrees. Where a Joint Investigative interview has been video recorded the original will be labelled and secured for Court purposes by the police. The working copy will be available for viewing by Trust or R & I Unit staff by arrangement with the officer in charge of the case. A log will be completed on each occasion that the tape is viewed by anyone and will detail the reasons for its having been viewed. This will be retained with the working copy of the tape.

8.33 Arrangements for viewing the tape by persons other than those identified above, e.g. defence or any subsequent court hearing, will be the responsibility of the police. PSNI General Order C(c) 70/96

must be complied with. Where investigation involves police and health and social services participation, the police officer in the case will be responsible as the prime keeper of all exhibits, letters, drawings, notes, etc made.

Review of ongoing management of the case

8.34 When the formal joint interview process has been concluded there may be a need for further inter-agency discussions, outside of any judicial procedures, to agree a course of action to address the practical and emotional implications for the vulnerable adult, his/her carers and staff involved in the case. In the majority of cases this can be most comprehensively dealt with by convening a Case Conference, although other, less formalised, mechanisms should be considered to optimise client/family involvement in the process. This is the responsibility of the designated officer from the relevant Trust in consultation with PSNI colleagues. Consultation should also take place on an inter-agency basis to identify the need for any staff debriefing/counselling which may be required as a result of the work which has been undertaken.

Glossary

and Appendices

Glossary

‘Achieving Best Evidence’

A voluntary code of practice for interviewing vulnerable witnesses for criminal proceedings and where video is used to record the witness’s testimony.

Arrestable Offence

An offence which carries a penalty of five years or more imprisonment. Serious assaults, sexual assaults, dishonesty offences, criminal damage and threats to kill are all arrestable offences.

CARE (Child Abuse Rape Enquiry) Unit

Police team of detective officers with specific responsibility for the investigation of cases involving child abuse or sexual offence.

Case Conference

A meeting of those involved in a case which can include the client/victim. The purpose is to establish potential risk to the individual and what action, if any, would be required.

CID (Criminal Investigation Department)

Police team of detective officers based in each District Command Unit with responsibility for the investigation of crime other than sexual crime.

Cross Examination

The secondary stage of evidence giving in Court where the testimony that a witness has already given is examined by counsel for the defence.

Counsel for the Defence

The legal representative responsible for conducting the case for the defence.

Designated Officer

Person within the Trust responsible for managing the investigation. The title used can vary, for example in the NHSSB they are known as Adult Protection Co-ordinators.

DCU (District Command Unit)

Geographical police area based on local council boundaries and which has its own command and resource structure. There are presently 29 Police DCU's in Northern Ireland.

DCU Crime Manager

The detective officer responsible for the investigation of crime and in charge of CID within a DCU. Detective Chief Inspector or Detective Inspector rank.

Director of Public Prosecutions

A body of legal staff who work independently from the Police and who are responsible for directing on cases and conducting trials of defendants in more complex cases.

Evidence

The term 'evidence' in its legal sense embraces all matters exclusive of mere argument, which can be placed before a Court to prove or disprove any matter or fact, the truth of which is the subject of judicial investigation.

Evidence-In-Chief

The initial stage of giving evidence in Court where the witness is taken through their evidence by counsel for the prosecution.

Form 38/36

A form used for making a written record of a witness's evidence where video is not considered an appropriate form of recording. Generally known as a 'statement'.

Hearsay Evidence

Evidence of what a person has heard another person, not the accused, say. It is not admissible in criminal proceedings.

Investigating Officer

Professional, within the Trust, responsible for investigating the alleged abuse. Their role is to establish the facts, look at alternatives available and to provide counselling and support.

Line Manager

Management Grade within the Trust to whom an individual directly reports.

Live Television Link

A system allowed under the Police and Criminal Evidence (NI) Order 1989 whereby certain witnesses can give evidence from a television monitor in a room separate from the main body of the Court.

NISCC (Northern Ireland Social Care Council)

The Council was established in October 2002 as the body for accrediting, regulating and monitoring the social care workforce, in addition to the development of professional standards and training arrangements. The Council will eventually deal with issues of professional malpractices.

Nominated Officer

The Trust staff member who has been delegated the role of managing investigations of suspected, alleged or confirmed instances of abuse against vulnerable adults.

Points to Prove

The ingredients of a criminal offence, each of which must be satisfactorily proven in a criminal trial.

Police General Order

A written instruction, which is issued to the PSNI.

Protection Plan

This is a plan developed to clarify the protection measures put in place to protect the individual. Roles and responsibilities for protecting the individual are clearly identified.

Registered Facilities

Voluntary or private care facilities registered and inspected by Health and Social Services Board Registration & Inspection Units.

Third Party Material

Matters of potential relevance to a police investigation, which are not in possession of PSNI.

APPENDIX A

Out of Hours Emergency Social Work - Contact Numbers

Eastern Health and Social Services Board Knockbracken Healthcare Park	028 9056 5444
Northern Health and Social Services Board Holywell Hospital	028 9446 8833
Western Health and Social Services Board Altnagelvin Hospital	028 7134 5171
Southern Health and Social Services Board Daisy Hill Hospital	028 3083 5000

Police Service of Northern Ireland – Contact Number

Police Exchange for Northern Ireland Brooklyn	028 9065 0222

APPENDIX B
AJP1

ADULT PROTECTION - RECORD OF JOINT AGENCY CONSULTATION

Referral by telephone on _____/_____/_____
To: ____________________________ Designation: ____________________
Person referring: ________________ Designation: ____________________
Address: ____
_________________________________ Contact Tel No: _________________

Name of Vulnerable Adult: __________________________ DOB: __/__/___
Home Address: ____
____
Present Location: ____
Gender*: M ☐ F ☐

Nature of Vulnerability*: ☐ Frail Older Person ☐ Dementia
☐ Learning Disability ☐ Physical/Sensory Disability ☐ Mental Illness
☐ Other (please specify) ____

Is the Vulnerable Adult subject to any legal/statutory status?*
(eg: Guardianship, Non Molestation Order) Yes ☐ No ☐
If yes please provide details: ____

Details of any current or past involvement with Social Services, Police and/or Registration and Inspection Unit: ______________________________________
____

Name of Carer/Next of Kin: ____
Address: ____
_____________________________________ Contact Tel No: ______________

WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?*

☐ Physical ☐ Sexual ☐ Psychological/Emotional
☐ Financial ☐ Neglect ☐ Institutional Abuse
☐ Other (please specify) ____

HAS THERE BEEN PREVIOUS CONCERN OR EVIDENCE OF ABUSE?*

Yes ☐ No ☐ Don’t know ☐
If yes, what was the nature of the concern and the outcome: ______________
____

* Please tick appropriate box/es.

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AND COPY TO SOCIAL SERVICES

Outcome of Joint Agency Consultation*

Single Agency Investigation by:
Social Services ☐ Police ☐ Registration & Inspection ☐

Joint Investigation by:
Social Services ☐ Police ☐ Registration & Inspection ☐

OR

Protocol for joint investigation of alleged and suspected cases of abuse of vulnerable adults ☐
Please specify if any other follow up will take place.

____

____

Signature of person completing form: ______________________________

Designation: ____

Date: ________________________

* Please tick appropriate box/es.

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APPENDIX C
AJP2

ADULT PROTECTION - STRATEGY FOR INVESTIGATION

Name of Vulnerable Adult ______________________ DOB: __/___/__

(A) PEOPLE IN ATTENDANCE/INVOLVED (NAME & AGENCY):

____

____

OTHERS CONSULTED:

____

____

(B) INITIAL STRATEGY: Date: ___/___/___

____

____

____

Next of Kin/Carer to be informed: YES/NO By Whom: ___________

(i) Amendments to strategy Date: ___________

____

____

____

Telephone/Meeting*
Persons Involved/Designation:
____
____

(ii) Amendments to strategy Date: ___________

____

____

____

Telephone/Meeting*
Persons Involved/Designation:
____
____

(C) PERSONS TO BE INTERVIEWED

1 Person making the allegation to clarify all facts about referral

Name: ____

Address: ____

*Please delete as appropriate

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2 Next of kin or other carers:

Name: ________________ Relationship to Vulnerable Adult: _______

Address: ____

3 Significant others
(attach separate sheet if necessary)
Name: ________________________
Relationship: ___________________
Address: _______________________
____

Date & Time: _______________
Venue: ____________________
Who will conduct:
SW: ______________________
PSNI: _____________________
Other: _____________________

4 The Vulnerable Adult
Name: ________________________
Address: _______________________

Date & Time: _______________
Venue: ____________________
Who will conduct:
SW: ______________________
PSNI: _____________________
Other: _____________________

5 The Alleged Perpetrator
Name: _________________________
DOB: __________________________
Address: _______________________
____

Date & Time: _______________
Venue: ____________________
Who will conduct:
SW: ______________________
PSNI: _____________________
Other: _____________________

Relationship to Vulnerable Adult: _____________________________

(D) Has a statement of complaint been made? YES/NO*

By whom: _______________________

Does the vulnerable adult have the capacity to:

(a) Consent to interview? YES/NO*

(b) Consent to medical examination? YES/NO*

Has the vulnerable adult consented to:

Interview? YES/NO*

Medical? YES/NO*

On what basis were these decisions made? _____________________

____

____

Signature of person completing form: __________________________

Designation: _____________________ Date: __________________

*Please delete as appropriate

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APPENDIX D
AJP3

ADULT PROTECTION - CLARIFICATION DISCUSSION

Name: ____________________________________ DOB: ____/____/____

Address: ____

____

Date: _____________________________________ Time: _______________

Venue: ____

Persons Present: ____

____

CONSIDERATIONS:

1 Has the adult previously made a clear disclosure of abuse or are there substantive grounds for suspecting abuse has occurred?

Comment: ____

____

2 Is the adult willing to engage in an interview?

Comment: ____

____

3 Is the adult able to engage in an interview?

Comment: ____

____

4 Has the purpose of the interview been explained to the adult?

Comment: ____

____

5 Which format is the most suitable for the interview? If a video interview appears to be the most appropriate option assess the adult's willingness to be interviewed on videotape.

Comment: ____

____

6 Decision: VIDEO STATEMENT QUESTION AND ANSWER

(Circle format to be used)

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NATURE OF DISCUSSION:

CONTEMPORANEOUS, VERBATIM RECORD OF DISCLOSURE:

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(Please close with diagonal line)

PERSON MAKING NOTES: ____

Responsibility for completion rests with either:
Police or Social Services

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Protocol for Joint Investigation

by

Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland

SEPTEMBER 2004

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MAHI - STM - 101 - 005799

BT Mod 3 Witness Stmt 20 Mar 2023 PART 4 OF 9 Exhibit Bundle (3 of 8) (T05-T06) (pp5404-8369 of 20966) (this part 2966 pages)

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FOREWORD

There are few areas of work where effective collaboration between staff in different agencies is as essential as the investigation of child abuse. It is also a very complex area of practice. Our knowledge and understanding of the phenomenon of child abuse has grown extensively over the last two decades. This knowledge must be incorporated within the day-to-day work of social workers and police officers if we are to ensure that the welfare of children remains paramount.

This is the fourth edition of the Protocol for Joint Investigation. Each revision has built on developments in our knowledge and experience. The Protocol for Joint Investigation was introduced in Northern Ireland in November 1991. It drew heavily on the recommendations of the Cleveland Report and in particular the importance of ensuring that children were not further harmed by the very investigative process which was there to help them.

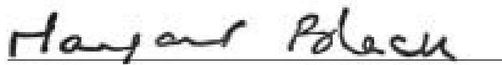
The Protocol for Joint Investigation was revised in March of 1996. This took account of changes in legislation, particularly the introduction of the Children's Evidence (NI) Order 1995 and the associated Memorandum of Good Practice. It also addressed a number of key practice issues identified in a province wide evaluation of the Protocol that had been carried out in 1994.

The third edition, took account of the changes brought about as a result of the implementation of the Children (NI) Order 1995 and its associated Regulations and Guidance, particularly Volume 6 "Co-operating to Protect Children". It drew heavily on the experience of practitioners and reflected the growing confidence, respect and trust between staff working in this difficult and demanding area.

It is recognised that there will always be a need to keep policies and procedures under review. Therefore, a review of the Protocol for Joint Investigation was commenced April 2003. This fourth edition of the Protocol for Joint Investigation takes into account the developments in both legislation and practice since 1995. It is essential that joint investigative practice is supported by effective professional training for

those social workers and police officers involved in investigations of alleged or suspected abuse.

The Core Group would like to place on record its thanks to all of those who contributed to this review and those who have supported and will continue to support its implementation. We would also like to acknowledge the high levels of professionalism of the social workers and police officers who work day and daily in the complex area of child protection.



Margaret Black (Mrs)
Chair - Core Group

1 INTRODUCTION

1.1 The first Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse was introduced in Northern Ireland in November 1991. It drew heavily on the recommendations of the Cleveland Report which advocated that the welfare of the child was paramount and that there should be clear procedures to ensure that children were not further abused by the investigative process.

1.2 Following an evaluation of this Protocol for Joint Investigation in 1994 and changes in legislation, particularly the introduction of the Children's Evidence (NI) Order 1995 and its associated Memorandum of Good Practice, a second edition was produced in March 1996. A third edition of the Protocol for Joint Investigation (1998), was necessitated by the implementation of the Children (NI) Order 1995.

1.3 Following implementation of the Criminal Evidence (NI) Order 1999 and its accompanying guidance "Achieving Best Evidence in Criminal Proceedings", it was necessary to carry out a full revision of the Protocol for Joint Investigation. This also provided opportunity for the inclusion of other developments in evidential interviewing, practice and procedures.

1.4 The Children (NI) Order 1995 recognises a child to be someone under 18 years of age. Children are also defined as vulnerable by reason of their age. The Criminal Evidence (NI) Order 1999 states that children under 17 years of age, appearing as defence or prosecution witnesses in criminal proceedings are eligible for Special Measures to assist them in providing their evidence and having their evidence heard at court. For young people who are over 17 years Special Measures may be available where other vulnerabilities are present, eg; learning disabilities, physical disabilities and mental ill-health. The implications of these statutes will be explained later in this document. The use of the word child in this document denotes children and young persons.

1.5 The 'Achieving Best Evidence' Guidance, which replaces the 1997 'Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings', provides detailed

description of good practice in interviewing children to ensure that best evidence is achieved for criminal proceedings. The Criminal Evidence (NI) Order 1999 also makes provision for a number of new 'Special Measures' that will facilitate children and young people to provide evidence in criminal courts.

1.6 Recommendations from the Victoria Climbie Inquiry, working groups established by the Regional Core Group, changes to Children Order Regulations and Guidance Volume 6 and issues raised by practitioners and trainers have been incorporated in this revision of the Protocol for Joint Investigation.

1.7 Although other agencies will be involved in aspects of the investigative process, the Police, Social Services and the NSPCC are primarily responsible for investigation. This Protocol for Joint Investigation is designed to ensure staff required to work together from the three agencies do so in the best interests of individual children.

1.8 The Review has taken into consideration new legislation and a number of important publications that include:

- Co-operating to Safeguard Children 2003
- The Criminal Evidence (NI) Order 1999
- Achieving Best Evidence in Criminal Proceedings
- Northern Ireland Act 1998 Section 75
- Human Rights Act 2000
- Protection of Children & Vulnerable Adults (NI) Order 2003
- Victoria Climbie Inquiry 2003
- Magistrates Court Rules (NI) 1984
- Criminal Justice (Miscellaneous Provisions) Act (NI) 1968
- Complex Child Abuse Investigations: Inter-Agency Issues - Guidance (May 2002) Department of Health and Home Office.

"The partners involved in the development of this protocol are committed to promoting equality of opportunity and good relations in all aspects of their work.

Section 75 of the Northern Ireland Act 1998 requires us 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; and
- Persons with dependants and persons without.

We are also required to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

The Human Rights Act, which came into effect on 2 October 2000, makes it unlawful to act in a way, which is incompatible with the European Convention and Human Rights. In keeping with these legislative requirements this protocol has been screened from an equality of opportunity and human rights perspective.

1.9 The revised Protocol for Joint Investigation updates the framework for joint investigative working. The Joint Protocol Review Group recognises the complexities and difficulties faced by practitioners from Police, Social Services and NSPCC. It is important that all other relevant agencies are active participants in the information-sharing, early assessment, preparation and planning processes in the investigation of alleged or suspected cases of child abuse.

1.10 Investigating social workers and police officers must read this Protocol for Joint Investigation in conjunction with 'Achieving Best Evidence in Criminal Proceedings', and individual agency protocols and direction in responding to alleged or suspected cases of child abuse.

Principles underpinning the Protocol for Joint Investigation

1.11 Irrespective of any envisaged evidential function, all investigative interviews must primarily address the needs of the child concerned and must make the child's welfare the first priority. The joint investigative interview will need to fulfill the relevant legal requirements as well as being competently conducted in terms of communicating with the child and throughout will need to be sensitive to the child's needs.

1.12 The following principles should apply to all investigations:

- The child's welfare must always be paramount and this overrides all other considerations;
- A proper balance must be struck between protecting children and respecting the rights and needs of parent and families; but where there is conflict, the child's interests are paramount;
- Children have a right to be heard, to be listened to and to be taken seriously. Taking account of their age and understanding they should be consulted and involved in all matters and decisions which may affect their lives;
- Parents/carers have a right to respect and should be consulted and involved in matters which concern their families;
- Children and Families have equal access to services across the region;
- Actions taken to protect a child, including investigation, should not cause the child unnecessary distress or add to any damage already suffered;
- Intervention should not deal with the child in isolation: the child must be considered in a family setting, with the impact of concerns also informing an assessment of the needs of other children within the family;
- Where it is necessary to protect the child from abuse, alternatives should be explored which do not involve moving the child and which minimise disruption of the family;

- Actions taken by agencies must be considered and well informed so that they are sensitive to and take account of the child's age, gender, stage of development, physical or mental disability, religion, culture, language, race and, in relation to adolescents, sexual orientation;
- All agencies concerned with the protection of children must work together on an inter-agency basis in the best interests of children and their families; and
- Each agency must have an understanding of each other's professional values and accept their respective roles, powers and responsibilities.

1.13 This Protocol for Joint Investigation offers an agreed way of working which should ensure:

- The processes minimise distress to the child by maximising the co-operation of services and resources essential to the investigation;
- Child Protection Procedures are properly followed;
- Differences of opinion are resolved through line management at local level but where this is not possible or where the issues are very complex, the issues should be referred to the Area Child Protection Committee; and
- Records are maintained and processes monitored and evaluated. It should be noted that all documents produced in an investigation will be subject to disclosure in criminal cases and discovery in civil cases. This will include PJI 1 – PJI 9 forms (See Appendix A).

Definition of Child Abuse

1.14 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.

Co-Operating to Safeguard Children (DHSS&PS 2003) defines abuse as follows:

Physical Abuse

1.15 Physical abuse is the deliberate physical injury to a child, or the willful 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

1.16 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 children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some levels 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 children to emotional abuse.

Sexual Abuse

1.17 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 looking at, or the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.[1]

1.18 In recent years, many who have sexually abused children have used electronic technology such as the Internet and mobile telephone. This fact needs to be borne in mind by investigators.

---

[1] 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 purposes 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 matter 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.

Reference: "Co-Operating to Safeguard Children", paragraph 6.75 and 6.76.

Neglect

1.19 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 foods, 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.

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

1.21 These types of abuse apply equally to children with disabilities but the abuse may take slightly different forms, for example, lack of supervision, or the use of physical restraints such as being confined to a wheelchair or bed.

1.22 Article 66 of the Children (NI) Order 1995, places a duty on Health & Social Services Boards and Trusts to investigate whether a child is suffering or likely to suffer "significant harm". As child abuse whether sexual, physical, emotional or neglect may result in significant harm, Social Services have a duty to investigate.

1.23 The Police Service of Northern Ireland have a duty to investigate criminal offences alleged or suspected to have been committed within Northern Ireland. As child abuse in its various forms constitutes criminal offences Police have a duty to investigate.

Record Keeping

1.24 As investigations are likely to be subjected to some level of review, judicial or otherwise, accurate and timely record keeping is essential. Record keeping will include accurate details of the following:

- Referral information to both Social Services and Police including completion of appropriate pro-formas;
- Communications between the Police, Social Services or others pertaining to the investigation;
- Strategy discussions including grounds for decisions, identified actions and timeframes;
- Contacts with children including Clarification Discussions;
- Interviews with witnesses including children; and
- Medical examinations;

2 INVESTIGATION OF ALLEGATIONS OF ABUSE

Context

2.1 The general welfare principle, as expressed in The Children (NI) Order 1995, places a duty on Health & Social Services Trusts to provide services for all children in need within their areas. Any concerns about the welfare of children should be referred to the local Health & Social Services Trust to ensure that families are offered support whenever children are assessed as "in need" in accordance with Article 18 of the Children Order.

2.2 Social Services are tasked with statutory responsibility for child protection investigation and have a statutory responsibility to make, or cause to be made, inquiries when there is "reasonable cause to suspect that a child who lives, or is found, in the authority's area is suffering, or is likely to suffer, significant harm" (Children (NI) Order 1995 Article 66 1b). Investigation will include conducting an initial assessment, liaising with the family and other key professionals, to assess the child's needs for support and protection. These inquiries must lead to an assessment as to whether action is needed to safeguard or promote the child's welfare.

2.3 The National Society for the Prevention of Cruelty to Children (NSPCC) also carry statutory powers to investigate.

2.4 Police are tasked with statutory responsibility to prevent and detect crime and to gather evidence in the investigation of alleged or suspected criminal offences committed against children. The foremost objective however, in common with Health & Social Services Trusts and NSPCC, will be the welfare and protection of the child.

2.5 The Police, Social Services and NSPCC each have their own roles and responsibilities in investigation. They also have specialist skills in terms of assessing and investigating allegations of child abuse. In every investigation of suspected or alleged child abuse it is necessary for these skills to be combined to provide maximum protection for those children who are at risk or have suffered significant harm.

2.6 Investigations may be joint or single agency subject to the nature and circumstances of the case. There may be cases of poor parenting and situations that may have innocent explanations which need not be “criminalised” by involving Police from the outset. Where there is doubt, consultation and discussion should take place between Social Services and Police.

2.7 The purpose of this Protocol for Joint Investigation is to detail how police officers and social workers co-ordinate their investigation.

Confirmation of alleged or suspected abuse to Police or Social Services

2.8 In all cases where a member of the public or a professional practitioner has reasonable cause to suspect that a child has been subject, or is being subjected to neglect, physical abuse, sexual abuse or emotional abuse as described in Chapter 1 Paragraphs 1.14 – 1.22, that concern must formally be referred to the Social Services, NSPCC or the Police.

Information Gathering

2.9 Following this referral nominated officers from each agency will gather information for consultation and assessment which will be the basis for making a decision as to the need for a joint investigation. This should be recorded in the relevant section of the PJI 1 Form.

2.10 The nominated social worker will consult with the General Practitioner and any other professional or other person whose knowledge of the child or family may be relevant to the investigation of the case.

2.11 Where relevant the nominated police officer will check the Integrated Criminal Information System, (ICIS), for relevant information that may be of use in reaching a decision about management of the case.

2.12 The information gained from professionals or other persons who may have knowledge of the child, family or circumstances of the child should always influence the decision about future action. This may not be possible in a minority of cases, eg; referrals will present which

require immediate action by one or other of the agencies involved to ensure the protection of the child or the apprehension of a suspect.

Consultation and Initial Assessment

2.13 The receiving agency will not automatically treat referrals as child abuse referrals in the first instance. This should avoid needless labeling of concerns as "child abuse".

2.14 The agency receiving the referral will gather as much information as possible from the referrer and other sources. Immediate consultation will then take place between Social Services and Police in relation to the referral.

2.15 Each referral will be subject to an early exchange of information between Social Services and Police, which will facilitate an initial assessment.

2.16 If there is reason to suspect a criminal offence in any initial referral to Social Services or NSPCC they will immediately consult with the Police.

2.17 Where Police either receive information, or come across a situation that raises concerns about child protection, they will refer the concern to Social Services or NSPCC.

Outcome of Initial Assessment

2.18 The initial assessment will establish the nature of the concerns expressed in the referral. The conclusion of this assessment will determine the most appropriate action and the next step.

2.19 One or more of the following decisions must be made at the conclusion of the initial assessment, having consideration to the Area Child Protection Procedures and the Criteria for Joint/Single Investigations:

- A referral for Family Support - Article 18, (Social Services);
- An Article 66 inquiry - Authority's duty to Investigate, (Social Services);

- A Joint Investigation, (Police and Social Services);
- Criminal Investigation, (Police); and
- No further action is considered appropriate.

NB if the Joint Protocol process ceases after an initial assessment please indicate on the PJI 2 (a) and complete a PJI7.

Criteria for Investigation

2.20 A joint Police and Social Services investigation will not be deemed necessary in every case. The decision making process should be guided by the following criteria:

<u>Single Agency Investigation</u>

2.21 It is important that the single agency approach is agreed either at consultation level and/or at the Strategy Discussion/Meeting, and the grounds recorded.

<u>Social Services</u>

2.22 Where a case falls within the following criteria, Social Services will conduct a single agency investigation:

- Those involving purely emotional abuse (no physical concern apparent);
- Those involving physical abuse of a minor nature;
- Those involving minor neglect through inappropriate supervision or poor parenting skills;
- Those involving the suspicion of sexual abuse which arises from indirect concern or the over-sexualised behaviour of a child; and
- Where a Schedule One Offender (Children & Young Persons (NI) Act 1968) moves into the household .

2.23 If during the course of an inquiry into any case as outlined above it is apparent that the joint investigation criteria are met,

contact should be made with Police and a joint investigation should begin at that stage.

2.24 It should be noted that in situations where a Trust holds parental responsibility for the child, or allegations have been made or suspicion arises in relation to a member of a Trusts own staff, or where there is likely to be a potential conflict of interest, it is important to consider whether it is appropriate for that Trust to conduct the child protection enquiry. (See Co-operating to Safeguard Children 6.9 – 6.17).

Police

2.25 There may be exceptional cases when a single agency police investigation is an appropriate response, for example; those where the alleged Offender is not known to the child or child's family, (i.e. stranger abuse), and where there are no child protection concerns after consultation with Social Services.

2.26 Throughout a single agency investigation by Police, the Investigating Officer will consider the ongoing needs of the child and family. The need for a referral to Social Services for supportive or therapeutic services should always be considered.

Joint Investigation

2.27 If a Joint Investigation is indicated a PJI1 form must be completed by the agency making the referral, (NSPCC, Social Services or Police), - PJI 1 (See Appendix A).

A joint investigation will begin whenever there is an allegation or reasonable suspicion that one of the criminal offences described below has been committed against a child:

- Any sexual offence committed against a child;
- Serious neglect or ill-treatment which is actionable under Section 20 Children and Young Person Act 1968. All referrals prompting concern will require differentiation between those which are likely to lead to unnecessary suffering or injury to the health of the child and the minor instances which occur

through ignorance or poor parenting skills by the parent or carer. Minor instances may be better dealt with by agencies working with the family;

- Serious physical injury against a child. Within the terms of this particular criterion the term "serious physical injury" includes murder, manslaughter, any assault involving actual or grievous bodily harm and repeated assaults involving minor injury;

- Particular consideration should be given to the need for a joint investigation when either a child whose name is already on the Child Protection Register or a "looked after" child (Article 25 Children (NI) Order refers), sustains injuries. A child is "looked after" when he/she is in the care of a Health and Social Services Trust or is being provided with accommodation by a Trust;

- Other offences which involve unusual circumstances such as Organised or Institutionalised abuse, bizarre behavioural/medical conditions. such as Munchausen Syndrome by Proxy;

- In other cases of minor injury, the circumstances surrounding the incident should also be considered. Factors which may help in determining whether the threshold for joint investigation have been met include:

    - The age, special needs and vulnerability of the child.
    - A previous history of minor injuries.
    - If a weapon or implement was used.
    - Previous concerns from a caring agency.
    - The consistency with and clarity/credibility of the child's account of the injuries.
    - Other pre-disposing factors about the perpetrator, eg relevant criminal conviction, alcohol/drug abuse or mental health issues.

- Through these considerations, the ‘seriousness’ of the abuse can be determined. If there is any doubt about ‘seriousness’, further discussion should always occur between the two agencies. Disputes should be resolved by agreement between senior managers from the agencies involved.

It is important to note that the likelihood or otherwise of a prosecution is NOT the criterion for a joint investigation.

Criminal Allegations made by Adults of Abuse having Occurred in Childhood

2.28 Where an allegation has been made by an adult of abuse having occurred in childhood this will be the subject of a single agency Police investigation. Where the alleged abuser currently has contact with children a separate referral must be made to Social Services for consultation and assessment.

Confirmation of Referral of alleged or suspected abuse to Police or Social Services

2.29 In cases where a decision has been taken to conduct a Joint Investigation a PJI1 form must be completed by the agency making the referral, (NSPCC, Social Services or Police), - PJI 1 (See Appendix A).

Strategy Discussion/Meeting

2.30 When a decision has been made that a joint investigation should be undertaken by Police and Social Services and/or NSPCC, a Strategy Discussion must take place within 24 hours from referral unless good practice dictates otherwise. There will be occasions when it will be appropriate for the Strategy Discussion to take place by telephone, but in other instances depending on the complexity of the issues, the telephone discussion may have to be extended to a meeting. Such a meeting must take place within 3 working days of the referral. This allows sufficient time to complete an investigation before a Child Protection Case Conference, which if deemed necessary, should be held within 15 working days of the first Strategy Discussion.

2.31 The purpose of the Strategy Discussion or Strategy Meeting is to ensure an early exchange of information, and to clarify what action needs to be taken jointly or separately in the investigation. This discussion should be action-orientated with the purpose of planning the investigative steps.

2.32 The Strategy Discussion will always include Police and Social Services and, as appropriate, may include a Forensic Medical Officer, Paediatrician, other professionals and/or a person with special knowledge in dealing with children with disabilities. In the situation where an allegation is made against a member of staff of any agency, it may be necessary to include a representative of that person's agency or organisation in the Strategy Discussion.

2.33 Many investigations will involve more than one strategy discussion.

2.34 The Strategy Discussion should address the following points:

- Whether urgent action is needed to protect the child or children in the family and who will be responsible for such action?
- What other information is needed to complete the investigation and who will seek it?
- What issues of race, religion, culture, gender or special needs are raised in the case, how and by whom they are to be addressed and what advice needs to be sought? [2]
- Is a Clarification Discussion[3] with the child necessary, and if so, who should undertake this task? (Normally this should be done jointly).
- What specialist advice might be needed and who will obtain it?
- Who will be interviewed, by whom and the order in which the interviews will take place?
- Should a medical examination[4] be undertaken and if so, by whom? If medical examination is considered necessary form PJI 6 (See Appendix A) should be completed.

---

[2] See Achieving Best Evidence Paragraphs 2.32, 2.35 and 2.56 – 2.60

[3] Function of a Clarification Discussion is explained in the Joint Protocol Chapter 3, Paragraph 3.22

[4] See Achieving Best Evidence Section 2.33 – 2.35

- What other roles need to be performed and by whom, for example, supporting a parent?
- Arrangements for reporting back - all persons responsible for any part of the investigation must be clear about the arrangements for reporting back both orally and in writing. When initial investigations have been completed, a decision will be taken by Social Services in consultation with other agencies and professionals, on the need to convene a Child Protection Case Conference. It should be agreed that when the Joint Protocol process/investigation ends a PJI2, 2(a) and PJI 7 should be exchanged between the PSNI and Social Services.

2.35 In cases involving one perpetrator but more than 10 children the Strategy Discussion should consider adopting the model for large scale investigation. (Paragraph 6.4).

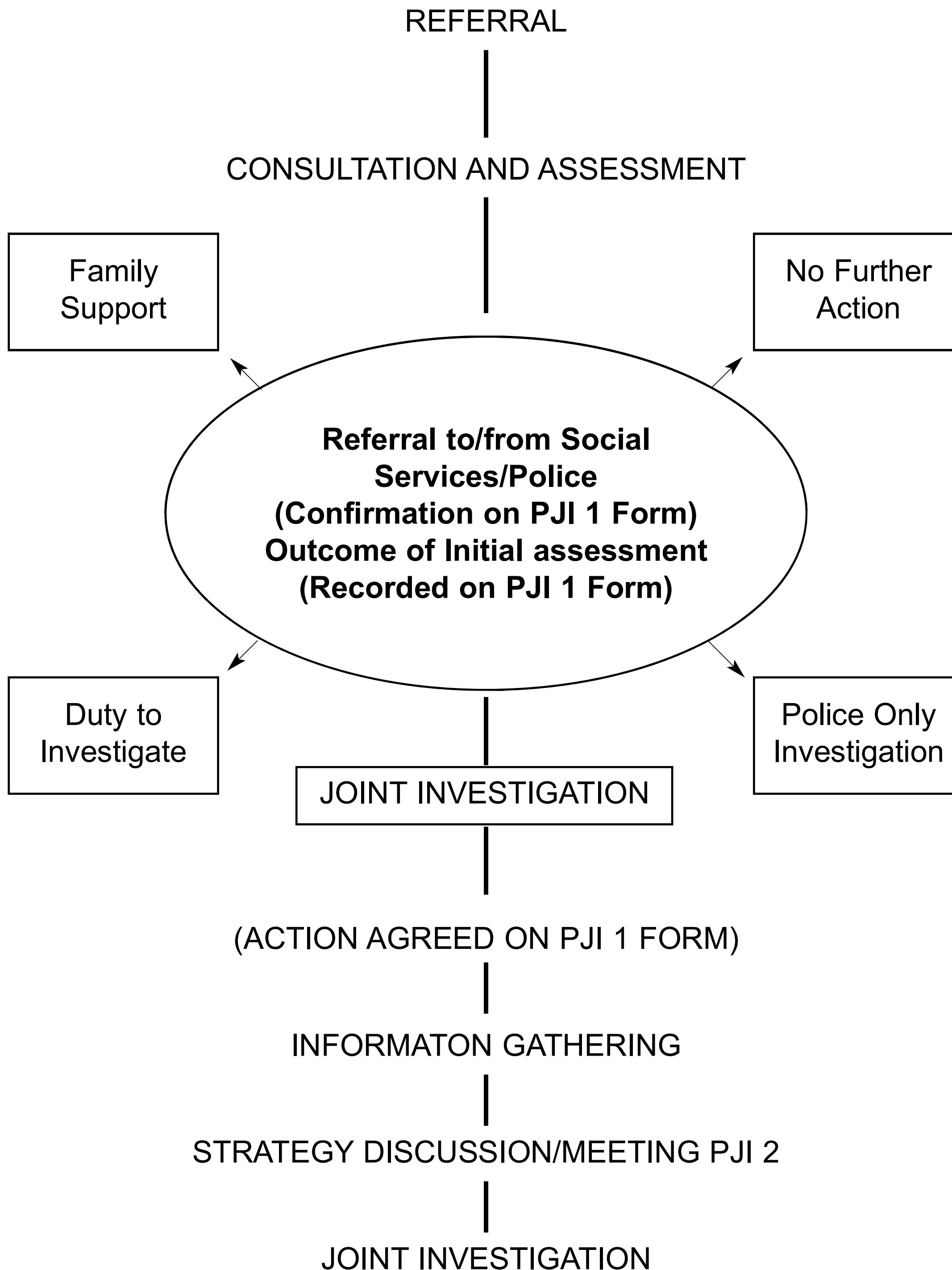
2.36 The Strategy Discussion will consider the future role of the Police in the Joint Investigation where there is no formal complaint or the complaint has been withdrawn. Both Police and Social Services should not lose sight of the fact that they have a continuing statutory responsibility to investigate fully any allegation of child abuse about which they have been made aware.

2.37 A record of the Strategy Discussion/Meeting must be completed using Form PJI2 (See Appendix A). It is the responsibility of Social Services to complete form PJI 2, (one in respect of each child), and forward the original to the Police. Where additional strategy discussion meetings take place details should be recorded on PJI 2 (a).

2.38 Persons completing any PJI forms should bear in mind the fact that the record contained on these forms may be subject to the scrutiny of criminal and civil courts. They need therefore to be complete, accurate and evidence based.

The flowchart overleaf illustrates the key stages which may lead to a Joint Investigation.

FLOWCHART REGARDING CONSULTATION, INITIAL ASSESSMENT, PLANNING AND JOINT INVESTIGATION



NB if at any stage the Joint Protocol process/investigation ends each agency should agree and the decision should be recorded on the PJI1, PJI2 (a) and PJI3 if applicable, and PJI7 must be **completed.**

3 Investigative Interviewing

3.1 Social Workers and Police Officers involved in the investigation of alleged and suspected cases of child abuse must, as a minimum, have completed Joint Protocol training. (See Chapter 8).

3.2 Where it is agreed in the Strategy Discussion, (Chapter 2, paragraph 2.20), that an investigative interview(s) is/are required, the following procedures will apply. The group planning the investigation at the Strategy Discussion/Meeting will make decisions on the following:

- Who needs to be interviewed;
- Sequence of interviews; and
- By whom interviews are to be conducted.

3.3 It will be the responsibility of each agency to ensure that staff are **supervised and supported** by managers in their own agency to monitor the investigation and to ensure that professional standards are maintained.

Who Needs to be Interviewed

Person who Made the Referral

3.4 The purpose of this interview is to determine the exact nature of the referral and the grounds on which it is based. The reliability of the referrer should be assessed and their ability to provide sources of corroboration. Their willingness to provide a statement and to give evidence should also be checked. The admissibility of evidence of an early complaint in sexual cases should be borne in mind.

The Parent(s) or Other Carers

3.5 Therapeutically, and emotionally, the role of a parent(s)/carer(s) is the most important single factor in terms of the prognosis for the child's recovery. It is important to be aware, however, that without intensive support, the parent(s)/carer(s) capacity to protect and help the child may be undermined.

Ideally, both parents should be present during this interview. However, in those cases where the protection of the child may be jeopardised or the criminal investigation may be impeded, it will be necessary to exclude a parent who is a suspected abuser, at this time.

3.6 The purpose of this interview is:

- To inform the parent(s) of the allegation;
- To assess their reaction to it;
- To advise them of the procedures for investigation;
- To explain the role of each agency;
- Obtain agreement to interview with child. (If refused, legal advice should be sought);
- Make arrangements for interview with the child and any other children in the household where this is thought necessary;
- Establish willingness to allow a medical examination of the child if necessary. (Consent form PJI 6 is completed by Doctor undertaking examination);
- In cases where a parent/carer is the suspect, establish whether the other parent/carer had any prior knowledge or suspicion of abuse, and especially whether the child made any attempt to tell that parent/carer; and
- Assess the parent/carer's ability and capacity to reassure, care and protect the child and their attitude to the suspected abuser.

3.7 Parent(s)/carer(s) should be advised that they may wish to seek legal advice.

<u>Child Witness</u>

3.8 Child witnesses will be interviewed using the Special Measures provided by Article 4 of the Criminal Evidence (NI) Order 1999 and its accompanying guidance "Achieving Best Evidence" following

assessment of the child's suitability for interviewing by video. The instructions contained in this protocol must be followed in respect of such interviews, (Chapter 4). If in any case a child witness has been deemed as not meeting the necessary criteria for video the child should be interviewed and their account recorded by Police in the form of a statement (Statements of Evidence Rule 149 of Magistrates Court Rules (NI) 1984 and Section 1 Criminal Justice (Miscellaneous Provisions) Act (NI) 1968).

3.9 A child witness may be a victim of abuse or have witnessed the abuse of another. Where a child has been a victim of abuse and a witness to the abuse of others primary consideration should be given to interviewing the child as a victim of abuse. Any information the child may have regarding the abuse of other children will fall broadly into two categories.

- Abuse they have witnessed, and
- Abuse they have heard about (hearsay).

3.10 In the early stages of the investigation, the latter category may be of vital importance in establishing the scene of abuse. However, considerable care is necessary regarding how and when this information is recorded. It should never be allowed to contaminate the child's primary evidence as a victim.

3.11 Hearsay evidence is generally not admissible in criminal courts, and could render some of the video evidence inadmissible, which may require the child to attend court to give their evidence in chief in person.

<u>Interviews with Other Children in the Household</u>

3.12 Arrangements for the interviews should follow the guidance for investigative interviews of a child (Chapter 4). The purpose of the investigative interview is as follows:

- To establish if any other child in the household has been abused; and
- To see if any other child can provide corroborative evidence of the alleged or suspected abuse.

Interview with any other Family Member or Friend

3.13 The purpose of this interview is to determine what knowledge this person may have about abuse of child/children and to ascertain what other information they might have about the child or the family relevant to the investigation and the overall care and protection provided for the child.

Sequence of Interviews

3.14 The sequence of interviews is a matter to be decided at the Strategy Discussion/Meeting on the basis of information available and should be part of a carefully planned strategy. Before interviewing the child about whom the concerns exist as much information as possible should be gathered from other witnesses.

By Whom Investigative Interviews are to be Conducted

3.15 The presenting circumstances will determine the person most appropriate to carry out investigative interviews. As the core purpose of investigative interviews is the gathering of criminal evidence, it will be the responsibility of Police, in virtually all situations, with the exception of interviews with children, to conduct interviews and to record in the most appropriate means the relevant evidence.

In relation to the investigative interview with a child consideration must be given to the provision of Special Measures set out in Achieving Best Evidence. (Chapter 4, paragraph 4.19).

3.16 The consultation and initial assessment described in paragraphs 2.9 – 2.13 may involve discussions with a child. Staff consulting with a child or children following a referral will do so only for the purpose of assessment and basic information gathering. Such actions should not be viewed as either a clarification discussion or an interview. Careful record must be made of all such consultations and assessments.

Special Measures Investigative Interview

3.17 The legislation (Children's Evidence (Northern Ireland) Order

1995) introduced the concept of a special arrangement for the obtaining and presentation of children's evidence in criminal courts. The Children's Evidence (NI) Order was repealed and replaced by the provisions of the Criminal Evidence (NI) Order 1999 commenced in June 2003. The Criminal Evidence Order provides for the evidence of children to be gathered and presented using what is described as a Special Measure. In this context children's evidence can be obtained using videotape. Investigative interviews with children must therefore be conducted in accordance with the guidelines attached to Special Measures, as set out in Achieving Best Evidence. For the purposes of this Protocol investigative interviews with children carried out on videotape will be referred to as Special Measures investigative interviews.

3.18 In the Special Measures Investigative Interviewing of child witnesses, two roles have been identified for the Interviewing Team: these are the FIRST INTERVIEWER (Formerly Interviewer) and SECOND INTERVIEWER (Formerly Controller). The functions and responsibilities of these roles are fully explained in Chapter 4.

The Method of Interview

3.19 Two alternative methods of interview and recording of evidence are available:

- Video Recorded Interview, (as per Criminal Evidence (NI) Order 1999, (Chapter 4).
- Interview and making of Statement, (as per Magistrates Court Rules (NI) 1984, Form 38/36).

3.20 Whilst these are the only two acceptable methods of interview in criminal proceedings, in circumstances where a child is not capable of making a statement or a video recorded interview, consideration should be given to having the child's evidence recorded in the form of questions and answers. The record of such an interview should be included in a statement made by the interviewer.

3.21 IN SITUATIONS WHERE THE CRITERIA FOR SPECIAL MEASURES INVESTIGATIVE INTERVIEW ARE MET, A VIDEO RECORDING MUST BE REGARDED AS THE PREFERRED METHOD OF INTERVIEW.

Child Witness Clarification Discussion

3.22 In making decisions about the method of interviewing child witnesses it will be necessary to have a short CLARIFICATION DISCUSSION. The specialist investigative interviewer who will conduct any subsequent interview should normally undertake this clarification discussion. However, where this is not possible, the clarification discussion may be carried out by other staff that have received joint protocol training.

3.23 The purpose of the Clarification Discussion is:

A To establish whether or not the child has anything to say about the allegations or suspicions which led to the referral.

The Clarification Discussion is not an investigative interview and should never replace or over-shadow the Joint Investigative interview with the child. The substance of the allegation or disclosure should not be part of the Clarification Discussion as these will be the subject of an investigative interview. Where a child makes a spontaneous disclosure during the course of a clarification discussion a contemporaneous, verbatim record of the child's statement should be made. It is important not to coach the child in respect of the interview.

B To assess the child's willingness and ability to pursue the matter through the police, and eventually to court, where appropriate.

- Those conducting a clarification discussion should take into account:
- The needs and circumstances of the child (eg; age, development, impairments, degree of trauma experienced, whether the child is now in a safe environment);
- The child's state of mind (eg; likely distress and/or shock);
- Perceived fears about intimidation and recrimination;
- The circumstances of the offence (eg; relationship of the child to alleged abuser); and
- Whether the use of video in the interview is likely to maximise the quality of that particular child's evidence.

C Taking into consideration the childs wishes and views, arrangements for the investigative interview should take into account:

- Location of interview;
- Time of interview;
- Preferred gender of interviewer; and
- Special requirements, eg; culture, disability.

Given the variety of children's backgrounds, and different circumstances leading to suspicion of abuse, there are no 'hard and fast' rules or unequivocal criteria which apply to the video recording of interviews. The following considerations should be taken into account before proceeding with any video interview with a child:

- The individual child's circumstances, current or previous contact with Social Services, previous concerns around parenting, neglect or abuse, and history of the current allegations;
- The purpose and likely value of a video recorded interview on this occasion;
- Competency, compellability and availability of the child for cross-examination;
- The child's ability and willingness to talk in a formal interview setting; and
- Preparation of the child before interview.

3.24 The record of the clarification discussion will be recorded on PJI 3 (See Appendix A) and it is the responsibility of the investigator conducting the clarification discussion to complete the form.

3.25 If the discussion includes a spontaneous disclosure of abuse, that part must be recorded verbatim and contemporaneously, or at the very least as soon as possible after the contact. Even if no criminal disclosure is made, accurate recording is essential as decisions about risk may be made on the strength of the clarification discussion.

3.26 An accurate and detailed record of this discussion must be made on Form PJI 3. If the Joint Protocol process/investigation is to end at this point, this should be recorded and PJI 7 must be completed.

ONCE A DECISION HAS BEEN MADE THAT A VIDEO RECORDED INTERVIEW OF A CHILD SHOULD BE CONDUCTED, A SPECIALIST INVESTIGATIVE INTERVIEWER WILL BE TASKED TO CARRY OUT THE INTERVIEW.

The Child who Becomes a Suspect

3.27 Children who are being interviewed as witnesses may make a statement that indicates they may have been party to the commission of a criminal offence. It should be remembered that a child under the age of 10 years has no criminal responsibility.

3.28 If a child witness, during the course of an interview, provides information that indicates he or she may have been involved in the commission of an offence, a decision will have to be made on whether to proceed or terminate the interview.

3.29 The interviewers should take a short break to consult on the matter, and be mindful of the need for sensitive handling of this situation.

3.30 If continuing the interview would be likely to impinge on the child's rights the interview should be terminated so that any further questioning can be carried out in accordance with the Police and Criminal Evidence (Northern Ireland) Order 1989.

3.31 When, following consultation, a decision is made that the child's evidence in relation to alleged or suspected abuse must be the priority the interview should proceed and follow the guidance contained in Achieving Best Evidence.

3.32 Whether a possibility remains that criminal proceedings could be brought against the child will depend upon the particular circumstances of the case and consultation between Social Services, Police and the Public Prosecution Service (PPS).

INTERVIEW WITH SUSPECTED ABUSER

3.33 The interview with the suspect should be carried out by Police in accordance with legislative requirements (Police and Criminal Evidence Order (NI) 1989).

3.34 The contents of any interview with the suspect, insofar as it has implications for the care and protection of the child, must be shared with Social Services.

Child Protection Procedures/Plan

3.35 The Area Child Protection Policies and Procedures must be followed in conjunction with every stage of the investigation including following interviews. This process will help determine at what point Child Protection Case Conferences are necessary.

Child Witness Counselling and Therapy

3.36 Once the interview with the child is complete, it should be possible for appropriate counselling and therapy to take place. Police and the PPS must be informed about the nature of such therapy in each case. (Achieving Best Evidence paragraphs 2.81 and 2.82).

THESE GUIDELINES MUST BE READ IN CONJUNCTION WITH ACHIEVING BEST EVIDENCE IN CRIMINAL PROCEEDINGS: GUIDANCE FOR VULNERABLE OR INTIMIDATED WITNESSES, INCLUDING CHILDREN ACCOMPANYING THE CRIMINAL EVIDENCE (NI) ORDER 1999

4 SPECIAL MEASURE INVESTIGATIVE INTERVIEWS

4.1 Only those staff who have received 'Specialist Investigative Interview' training will be eligible to undertake the roles of FIRST INTERVIEWER and SECOND INTERVIEWER in 'Special Measures' interviews in compliance with this section.

Introduction

4.2 The Criminal Evidence (NI) Order 1999 makes special provision for the gathering of evidence from vulnerable witnesses. Children (persons under 17 years), are included in the definition of vulnerable witnesses. These provisions which are referred to as 'Special Measures' have as their objective the enabling of young and vulnerable witnesses to give evidence in criminal courts and thereby have equality of access to justice. Persons over 17 years of age and who have vulnerabilities through learning disability, physical disability or mental health will have access to the 'Special Measures' and are catered for in the Protocol for the Joint Investigation of Alleged or Suspected Abuse Committed against Vulnerable Adults.

Purpose of Special Measures Investigative Interview with Children

4.3 Any video recorded interview serves two primary purposes. These are:

- Evidence gathering for use in criminal proceedings; and
- The examination in chief of the child witness.

4.4 In addition, any relevant information gained during the interview can also be used to inform child protection enquires under Article 66 of the Children (NI) Order 1995 and any subsequent actions to safeguard and promote the child's welfare, and in some cases, the welfare of other children.

Planning of the Investigative Interview

4.5 Special Measures Interviews should be planned and carried out in accordance with Achieving Best Evidence Chapter 2 Part A Planning and Conducting Interviews with Children.

4.6 The planning of the interview should be recorded using form PJI 5 (See Appendix A).

Interviewers must be given sufficient time to carry out this planning process, prior to a Special Measures Interview.

Child's Agreement to Video Interview

4.7 No video recording should be made of a child's evidence where there is a question over that child's competence to give evidence in criminal proceedings. It should be remembered that a video recorded interview becomes the witness's evidence-in-chief and therefore the witness can be legally compelled to attend court, give evidence and be available for cross-examination. It is important therefore that a full age-appropriate explanation of these implications is provided to the child and their agreement to investigative interview sought. Written consent to a video recorded interview is not required. (Achieving Best Evidence paragraph 2.68).

Attendance of Parent or Other Supportive Adult at Investigative Interview with a Child

4.8 The planning of the interview should include consideration of the inclusion of a support person in the interview, (an Interview Supporter). (Achieving Best Evidence paragraphs 2.40 – 2.44).

Venue of the Investigative Interview

4.9 The venue of the investigative interview has to take cognisance of the child's needs, travelling distances and the availability of functioning interview suites that meet the standards of Achieving Best Evidence.

Time and Length of Investigative Interview

4.10 The interviewing team should anticipate the likely number and length of video recorded interviews as part of the planning process. (Achieving Best Evidence paragraphs 2.53 - 2.55 and 2.127 – 2.128).

Preparing for the Investigative Interview

4.11 The Criminal Evidence (NI) Order 1999 is 'Permissive' legislation. The decision as to whether the investigative interview will be videotaped will be taken by the investigating police officer in accordance with the criteria set out in Achieving Best Evidence paragraphs 2.26 – 2.31. However, before making this decision, the officer must consult with Social Services or other relevant agencies and obtain the agreement of the child and/or parents. In arriving at this decision all agencies should be mindful that the best interests of the child are always paramount.

Criteria for Video Recording an Interview

4.12 Achieving Best Evidence identifies 3 categories of child witness (Paragraph 2.26). These are;

- Children giving evidence in sexual offence cases;
- Children giving evidence in cases involving an offence of violence, abduction or neglect; and
- Children giving evidence in all other cases.

4.13 Video recorded interviews should take place in all category (1) and (2) child witness cases, unless the child objects, and/or there are insurmountable difficulties which prevent the recording taking place. (This may include that the child has been involved in abuse involving video recording or photography).

4.14 In all other cases (category 3), the decision whether or not to video record an interview should take into account:

- The needs and circumstances of the child, (e.g. age, development, impairments, degree of trauma experienced, whether the child is now in a safe environment);
- Whether the measure is likely to maximize the quality of that particular child's evidence;
- The type and severity of offence;
- The circumstances of offence (e.g. relationship of the child to the alleged abuser);
- The child's state of mind (e.g. likely distress and/or shock); and
- Perceived fears about intimidation and recrimination.

Conducting a Special Measures Investigative Interview

4.15 Those conducting Special Measure investigative interviews should always consult Achieving Best Evidence (Part 2).

4.16 Prior to an investigative interview, where videotaping is to be undertaken, the interviewing team must ensure that the equipment is in working order. He/she must test the equipment to ensure vision and sound quality and ensure tapes are correctly prepared, checked and inserted. The earpiece should also be tested.

Further Investigative Interviews

4.17 Achieving Best Evidence paragraphs 2.127 – 2.128 provides clear instruction on conducting further interviews.

Roles in Special Measure Investigative Interviews

4.18 The two central roles identified for Special Measures investigative interviewing of child witnesses are FIRST INTERVIEWER and SECOND INTERVIEWER, (The interviewing team). The interviewing team will have responsibility for ensuring that the interview is conducted in accordance with the provisions of "Achieving Best Evidence".

First Interviewer

4.19 Each Special Measures investigative interview will be led by an interviewer, either a police officer or social worker who has received specialist investigative interview training and has been identified in the strategy discussion as the most suitable person to conduct the interview with the child. The choice of interviewer and the conduct of an interview must take into account the best interest of the child and any special need the child might have. The Police carry statutory responsibility for criminal investigation and Social Services carry statutory responsibility for safeguarding and promoting the welfare of children. Consequently a significant number of interviews will be undertaken by police officers but it is anticipated that there will be many occasions, where in the best interest of the child, Special Measures investigative interviews will be conducted by a social worker. (Achieving Best Evidence paragraphs 2.70 – 2.74).

4.20 The first interviewer will ensure that introductions, etc; are completed when video is being used and will have made him/herself fully conversant with the case prior to conducting an interview.

Second Interviewer

4.21 Special Measure investigative interviews that are conducted using video will require a Second Interviewer. The role of the second interviewer is to ensure:

- That the provisions set out in Achieving Best Evidence paragraph 2.74 are complied with;
- To assist the interviewer in identifying points to be proven in the interview evidence gathering; and
- That the interview is appropriately recorded including the sound track.

Records of Investigative Interviews with Children and their Maintenance

4.22 Statements of Evidence (Form 38/36) recorded from child witnesses will be retained by the Police for evidential purposes. A copy may be provided to Social Services, provided that the child

and/or parent or guardian agrees.

4.23 Where an interview has been video recorded the original will be labelled and secured for court purposes by Police. The working copy will be available for viewing by Social Services by prior arrangement with the police officer in charge of the case. A log will be completed on each occasion that the tape is viewed by anyone and detail the reasons for viewing. This will be retained with the working copy of the tape.

4.24 Arrangements for viewing the tape by persons other than Social Services, eg Defence or at any subsequent court hearing, will be the responsibility of the Police. PSNI General Order C(c) 70/96 must be complied with.

4.25 The police officer in charge of the case will be responsible as the prime keeper of all exhibits, including any drawings, letters, notes, etc made.

4.26 The disclosure of third party material which may be relevant to an investigation must be complied with in relation to the Criminal Procedures Investigation Act 1996.

When to Consult Specialists

4.27 Achieving Best Evidence paragraphs 2.56 – 2.60 provides guidance on issues such as race, gender, cultural, ethnic background and other life experiences of children. Due consideration should be given to consulting with and involvement of specialists in order to ensure that the interview is tailored to meet the particular needs and circumstances of the child.

5 CHILDREN WITH DISABILITIES

5.1 Achieving Best Evidence paragraphs 2.36 – 2.39, 2.138 – 2.139 and Appendix G provide clear advice on the interviewing of children with disabilities. The term 'children with disabilities' encompasses a wide range of impairments of varying severity. The guidance makes it clear that there is rarely any reason in principle why children with disabilities should not take part in a videotaped interview, provided the interview is carefully tailored to the particular needs and circumstances of the child.

Referral

5.2 When a referral concerning a child with disabilities is received, particular care must be taken to consult with a specialist worker. Specialist workers are those with particular areas of expertise in working with children with disabilities and will include some social workers, speech and language therapists, occupational therapists, psychologists and psychiatrists. The specialist worker can assist the investigative process in a number of ways:

- identifying who may have appropriate information;
- gathering appropriate information;
- deciding whether or not a particular child should be involved in an interview and what type of interview is appropriate;
- advising on the level of disability;
- assessing indicators of abuse;
- facilitating communication with the child; and
- facilitating the participation of those caring for the child.

5.3 Achieving Best Evidence at 2.73 states "Exceptionally, it may be in the interests of the child to be interviewed by an adult in whom he or she has already put confidence but who is not a member of the investigating team. Provided that such a person, has appropriate professional qualifications, is independent and impartial, is not a party to the proceedings, is prepared to co-operate with appropriately

trained interviewers and can accept adequate briefing, (including permitted questioning techniques), this possibility should not be precluded".

Strategy Discussion

5.4 When the decision is taken to proceed to a joint investigation it is vital that the specialist worker is actively involved. In addition to the considerations to be taken into account in respect of all children the specialist worker can give important advice on communicating with the child. It should be noted that it is preferable the specialist worker(s) know the particular child concerned as the advice can then be specific rather than general.

Communicative Competency of Child and Interviewer

5.5 It is necessary to establish that a child has a reliable method of communication that they can use intentionally and that the interviewer can understand either directly or through a suitable interpreter. This will require assessment if the child has specific difficulties with comprehension or use of language (vocabulary, ideas and grammar) associated with impairment or learning disability. Speech and language therapists, sign language interpreters or facilitators in augmentative communication may be required. **The competency of the interviewing adult in communicating will be the single greatest factor in determining whether a child achieves their potential in an interview situation.** The interviewer will also require information about the child's knowledge and understanding about themselves, about objects, about places and events about how these things may be affected by an impairment or learning disability.

Interpreters/Intermediaries

5.6 Achieving Best Evidence paragraphs 2.36 – 2.39 and 2.75 provide guidance on the use of interpreters and intermediaries.

5.7 Further guidance can be obtained from the ABCD training pack published by the ABCD consortium and available from the NSPCC. This pack contains many helpful suggestions for the investigation process involving children with disabilities.

Planning of Special Measures Investigative Interviews

5.8 The specialist worker has an essential role in contributing to the planning of the interview in order to take account of the child's specific disability (Achieving Best Evidence paragraphs 2.36 - 2.39* and 2.138 - 2.139).

* In relation to criminal proceedings, at least Stage 3 British Sign Language or Irish Sign Language Qualification is necessary.

6 INVESTIGATION OF ORGANISED ABUSE

Organised Abuse

Definition

6.1 For the purposes of this protocol the definition of organised abuse is outlined below.

6.2 Organised abuse means any abuse, sexual or physical, which involves an element of organization by two or more adults* who abuse a number of children in a variety of settings and may often encompass different forms of abuse.

6.3 Organised abuse occurs in three main settings:

- Families - Abusers in these cases come from extended or neighbouring families, and join together to abuse one another's children;
- Communities - In these cases, abusers often have no particular or pre-existing relationship with their intended victims, but target, entrap and then abuse children in the community. Victims may be drawn from a specific neighbourhood or estate, or from across a wider area; and
- Institutions - Where an adult or adults, employed in the public, private or voluntary sector, abuses the children he/she works with.

NB: **Although the instance of a single alleged abuser involving a large number of children/young people falls outside of this definition, those investigating may wish to consider the merits of using the proposed model for the investigation of organised abuse. It is also acknowledged that cases of organised abuse may involve abusers who are under 18 years of age.*

Types of Organised Abuse

6.4 The term “organised” abuse covers a range of abusing activity:

6.5 Family Based Abuse - Children are abused within an extended family network often crossing generations and involving several households. Adults outside the extended family may be drawn in and children may sometimes be prostituted. It differs from paedophile or child prostitution networks, not least because the victims are rarely recruited from outside the extended family and family contacts.

6.6 Paedophile Networks – There is more than one type of paedophile network. The most common are:

- Community Based Paedophile Networks;
- Worldwide Paedophile Networks linked by communication services and information technology, (eg; post, telephone, fax, e.mail, chat rooms and mobile phones).

6.7 These networks involve several individuals creating access to relatively large numbers of children. A network may be confined to a neighbourhood, may be spread over a wide geographical area, cross two or more national boundaries or be international. In worldwide networks paedophiles may or may not be known to each other.

6.8 Institutional Abuse - is abuse by adults working in a position of trust, either in an employed or voluntary capacity, in an organisation or association that has responsibility for or provides activities for children. The organisation or association acts as the organisational base bringing adults and children together which provides the opportunity for exploitation by abusers. Institutional abuse often involves abuse of many children over a long period of time.

6.9 Commercial Sexual Exploitation of Children – is the involvement of children in sexual activity for gain by adults. This might range from organised crime syndicates through to adult networks. In commercial sexual exploitation of children a distinction should be made between those adults who abuse children and those who recruit and provide children to facilitate sexual abuse. (For further details refer to Co-operating to Safeguard Children 6.46 – 6.55).

6.10 Indecent Images of Children – Over the last number of years an increasing number of individuals have been involved in the production of indecent images of children. These images are often distributed for sexual gratification and sometimes for financial gain. Whilst this production process might involve actual sexual abuse of children it may also involve the production of pseudo – photographs and the manipulation of innocent photographs. (Photographs include video, film, photographic data held electronically as well as the actual paper copy).

6.11 Ritual Abuse has been a contentious issue in child protection. Much of the controversy arises from how ritual abuse is conceptualised and whether a suspected abusers belief system and 'ritual' practices overlap with sexual or physical abuse.

6.12 Research, including that commissioned by the Department of Health, questions the existence of sufficient evidence to substantiate that ritual or satanic abuse occurs. (DOH 1998). Ultimately ritual abuse describes the context in which incidents are alleged to have taken place. It is therefore more important to focus on what happened to a child rather than how it happened.

6.13 It is necessary to recognise the limitations of the above categorisations as no feature is exclusive to any; rather they may overlap and exhibit interchangeable strains within a broad band of deviant sexual behaviour.

6.14 Of prime importance is the identification as soon as possible of the alleged abuse as "organised abuse" which must be dealt with under the model agreed by Police and Social Services.

Investigation of Organised Abuse

6.15 The procedure to be followed in the investigation of organised abuse will be dependent on the scale of the inquiry. Two categories of procedure have been developed for this purpose;

- Small Scale Organised Abuse Investigation and
- Large Scale Organised Abuse Investigation

6.16 Regardless of the scale of the investigation a Joint Investigative Team will be identified. Membership will include Police, Social Services and NSPCC Investigative Service. Such investigations will be jointly managed by the local Detective Inspector Child Protection and a Social Services manager of at least Assistant Principal Social Worker grade.

6.17 In cases of large scale organised abuse a Strategic Management group will be established by the local Trust Child Protection Panel. The purposes of this group will be to manage, co-ordinate and support the investigation.

6.18 Additional detailed guidance on organised child abuse can be found in Grappling with Smoke – Investigating and Managing Organised Child Sexual Abuse – A Good Practice Guide (1998) by Bernard Gallagher published by NSPCC and Complex Child Abuse Investigations: Inter-Agency Issues - Guidance (May 2002) Department of Health and Home Office.

Small Scale Investigation

6.19 Cases of organised child abuse will be classified as small scale where they involve;

- children within an extended family allegedly abused by two or more adult members of the family;
- children of different families in the community allegedly abused by two or more adult perpetrators; and
- a child or children within an institution allegedly abused by two or more adult perpetrators.

6.20 The appropriate Social Services Manager and the Detective Inspector Child Protection, having agreed that the alleged abuse is small scale, should ensure that the Joint Investigative Team is managed, co-ordinated and resourced to carry out the investigation. The local police Crime Managers, PSNI Detective Superintendant C2 and the local Trust Director of Social Services should be notified about each investigation of small scale organised abuse.

6.21 In the event of disagreement or uncertainty on the scale of the investigation required, the Social Services Manager and Detective Inspector should consult with the Trust Director of Social Services and the PSNI Detective Superintendant C2 respectively.

Large Scale Investigation

6.22 Cases of organised child abuse will be classified as large scale where they involve;

- 10 or more children within an extended family allegedly abused by two or more adult members of the family;
- 10 or more children of different families in the community allegedly abused by two or more adult perpetrators; and
- 10 or more children within an institution allegedly abused by one or more adult perpetrator.

6.23 Cases of large scale organised abuse may only become evident during the course of a routine investigation when the scale of abuse becomes clear over a period of time.

6.24 All cases of large scale organised abuse must be referred to the Chair of the relevant Trust **Child Protection Panel** who will establish a **Strategic Management Group to** manage and support the investigation and to provide the necessary response to the needs of the children involved. The Child Protection Panel Strategic Management Group is comprised of the following core representatives:

- Police Detective Superintendant C2;
- Social ServicesTrust Director of Social Services (for area in which allegations arise);
- A Senior Manager (Family and Child Care); and
- NSPCC Head of Investigation Service Northern Ireland.

6.25 This group will be convened and chaired by the police representative and all 3 organisations need to be present in order to constitute a quorum.

6.26 The Child Protection Panel Strategic Management Group permanent representatives may co-opt representation from other disciplines dependent on the type of alleged organised abuse under investigation.

6.27 Appropriate legal advice will be necessary and may be accessed through Police and Social Services legal advisers.

Functions of the Strategic Management Group

6.28 The Strategic Management Group will fulfill the functions of;

- Developing policy relating to individual investigations. To establish the principles and practice of the investigation and draw up a strategic plan and ensure regular review.

- Managing the investigative teams. To ensure that a Joint Investigative Team is established with sufficient personnel to undertake the investigation. This team will be jointly managed by a Police Detective Inspector or above and a Social Services Manager of Assistant Principal Social Worker grade or above. The selection of social workers and police officers will be from staff who have received relevant training. In selecting the team, consideration should be given to the issues of gender, race and disabilities (if any) of the alleged victims.

- Addressing the issue of resourcing of individual investigations. Resources fall into three categories:
    - Logistical resources - transport, accommodation, staff cover, etc;
    - Staff resources - numbers, conditions of service, back up; and
    - Counselling and support resources – counselling and support for children and their families and for workers involved in the investigation.

- In cases of organised abuse on a very large scale it may be necessary to request additional resources and assistance from the Area Child Protection Committee.

- To act in a consultative capacity to those professionals who are involved in the investigation.

- To ensure co-ordination between the key agencies, which have an interest in the progress of the investigation, regularly up-dated.

- To draw up a media strategy that will address who will take responsibility for responding to the media. To appoint a single spokesperson who will take responsibility for the issue of jointly agreed press releases and respond to the general demands of the media. Staff should be cautioned against speaking to the media unless they have the prior agreement of the Strategic Management Group.

Process

6.29 Following agreement between the Detective Inspector Child Protection and appropriate Social Services Senior Manager that a referral meets the criterion for large scale organised abuse:

- The Social Services Senior Manager will immediately notify the Trust Child Protection Panel Chair. The Detective Inspector Child Protection will immediately notify the Police Detective Superintendant C2;

- A Strategic Management Group will be established by the Trust Child Protection Panel Chair. It will be the responsibility of the Police to chair the Strategic Management Group to carry out the functions as identified by 6.5;

- The Area Child Protection Committee will be informed by the Trust Director of Social Services of each case of large scale organised abuse in their area and should be kept informed of progress of the investigation;

- The Strategic Management Group will meet within 2 working days and thereafter the Group will meet as required to discuss and review the progress of the investigation. The frequency will be determined by the complexity of the case. Managerial representation of the Investigative Team will be present at each meeting of the Strategic Management Group;

- The aim is to:
  - review all aspects of the strategy for investigation;
  - provide advice on the appropriate strategic direction;
  - ensure the continuing active co-operation of all relevant agencies;
  - agree a joint response to media interest; and
  - produce an accurate record of all meetings held.
- These Strategy Management Group Meetings have a specific remit and must not be confused with the regular briefing meetings held by the Joint Investigative Team.

6.30 The following issues will be considered at the Strategic Management Group Meeting:

- Aims of the Investigation
  - The protection of children;
  - Identification of possible criminal offences;
  - Evidence gathering; and
  - Consideration of other possible victims.
- *The Context of the Investigation*
  - The culture of the family/institution;
  - Ethnicity/race/diversity issues;
  - Consideration of resource implications;
  - Possible community interest and reaction;
  - Media/union/professional association interest; and
  - Public profile/status of alleged abuser(s) or victim(s).
- Handling Information
  - Arrangements for handling information obtained in the investigation;

- Managing Confidentiality; and
- The need to make other organisations aware of abuse allegations concerning their staff in order that they can take steps necessary for child protection, (See Co-operating to Safeguard Children Paragraphs 6.9 – 6.17).

- The process of the investigation
  - Co-ordinating identification and Interviews of children, witnesses and suspects across the wider geographical area;
  - Resources needed eg; staffing, accommodation including interview suites; Information Technology, administrative support;
  - Identify any specialist advice required, eg; legal, medical, psychiatric, cultural, special needs;
  - Involvement and response to parents/carers;
  - Consideration of family support and accommodation needs;
  - Impact of investigation on school/facility/institution;
  - Specific difficulties arising, eg; non co-operation of parents or organisations;
  - Regular debriefing within the investigating team; and
  - Staff care and support.

- The needs of Children and Families
  - Individual or group support for children and families;
  - All children named by other children, regardless of whether they made statements or not, require offers of individual help and their parent/s need advice;
  - Provision of accurate and updated information to the children who are the subject of an investigation and their parent/s;
  - Consider whether children and parents of children in the wider context of the investigation need to be informed of

what has happened in order that they might have the necessary knowledge to communicate any concerns or information they might have; and

  - Children and families given information about victim support and counselling agencies.

- Ending the investigation
  - Any follow-up work necessary with children and their families;
  - Witness support for court proceedings (See Chapter 7);
  - Final debriefing and communications; and
  - Evaluate and write up investigation for Trust Child Protection Panel and Area Child Protection Committee.

Abuse Across Trust and Police Boundaries

6.31 In the event of an organised child abuse investigation crossing Health and Social Services Trust/Police boundaries:

- The Detective Inspector Child Protection will immediately advise the appropriate Detective Inspector(s) Child Protection in other police areas and the Trust Director of Social Services will immediately advise the Director(s) of Social Services for the other Trust areas;

- The investigation will initially be undertaken by the Trust in whose area the child lives and the police area in which the alleged offence took place;

- An initial briefing session will be convened by the joint investigative team, to which representatives of relevant agencies in the other area(s) will be invited;

- The Trust Child Protection Panel Strategic Management Group will reconvene in order to take account of the extension to the investigation. It may be necessary to co-opt additional members to the Trust Child Protection Panel Strategic Management Group; and

- Similar provisions will also apply if an investigation crosses national and international boundaries.

Additional Considerations in the Investigation of Institutional Abuse

6.32 When dealing with abuse in a residential facility or other institution additional thought needs to be given to the management of the investigation to ensure:

- the continuing safety of the child;
- appropriate sharing of information; and
- lack of contamination of evidence.

6.33 In cases involving the investigation of abuse in institutional settings consideration should be given to “Co-operating to Safeguard Children” paragraphs 6.9 to 6.17.

6.34 The Trust Child Protection Panel Strategic Management Group should take active steps to be kept informed of all developments as they arise and give due cognisance to the potential difficulties for staff. The Strategic Management Group will ensure that lines of communication are established between the investigative team and the institution.

Welfare Principle

6.35 As with all investigations of abuse of children, care must be taken to ensure that the welfare of the child remains paramount. Whilst the gathering of criminal evidence is important, it must not be to the detriment of any child’s welfare. Although investigations to establish the standard of evidence for criminal proceedings are important, the need to protect the child, which requires a lesser standard of proof, should not be delayed. Individual/ group support to the children and their families as appropriate should always be considered.

Other Abuse

6.36 Other types of child abuse or neglect unconnected with the

investigation may come to the attention of the investigating team, for example, alleged familial abuse. These should be referred in the normal manner for joint investigation and not be dealt with by the team investigating the alleged organised abuse.

Conclusion of Joint Investigation

6.37 At the conclusion of the investigation the Joint Investigative Team should meet with the Trust Child Protection Panel Strategic Management Group to discuss the salient features of the investigation with a view to making recommendations for improvements either in policy or in practice. Recommendations should be communicated to the Chair of the Regional Core Group via the Trust Child Protection Panel.

6.38 A written report will then be sent by the Trust Child Protection Panel to the appropriate Area Child Protection Committee to inform future strategic developments.

7 THE YOUNG WITNESS SERVICE

7.1 Following the commencement of the Criminal Evidence (Northern Ireland) Order 1999 and the introduction of the Achieving Best Evidence Guidance a Witness Support Service has been established. This service is provided by NSPCC in respect of children (Young Witness Service) and Victim Support in respect of adults. All child witnesses, including children who are victims or witnesses to abuse, should be referred to the Young Witness Service who will provide preparation for and support at court. The following guidance should be followed in respect of referrals to the Young Witness Service.

7.2 Following completion of any investigation, the Police prepare a file for submission to the Public Prosecution Service who will make decisions on criminal prosecutions. Where criminal prosecution is directed the child or children interviewed during the investigation are likely to be called as witnesses in the criminal prosecution.

7.3 Children who have been victimised may have special difficulties as witnesses in criminal proceedings. They may need help to overcome the feeling that it is they, rather than the accused, who is on trial. The context and process of the trial itself may also bring back old memories and patterns of reaction and response for vulnerable witness. They may be especially sensitive to imputations of their own guilt or responsibility for the alleged actions of the accused. (Achieving Best Evidence Volume 2). Consequently any decision to call a child as a witness must have regard to these issues and any decision must recognise the paramountcy principle.

7.4 It is expected that the Police Investigating Officer and a representative of the Public Prosecution Service will liaise with the child and his/her family from the point of completion of the investigation to the issue of direction.

7.5 When a direction has been issued for prosecution the investigating officer/social worker must consider preparing any children involved for giving evidence in court. The support and preparation must be provided in accordance with Chapters 4 and 5 of Achieving Best Evidence in Criminal Proceedings.

7.6 When it becomes clear that a child may be required to testify in a criminal court a referral will be made to the NSPCC Young Witness Support Service. This service is presently available to all young people in Northern Ireland giving evidence in criminal cases at the Crown Court. The service may also assist, where possible, young witnesses in criminal cases at the Magistrate's Court. The investigating officer/social worker may wish to discuss any particular issues in specific cases with the Young Witness Service.

7.7 At the point of Arraignment and if the Defendant(s) enter a plea of "not guilty" all young witnesses who may be called to give evidence should be referred by Police to the Young Witness Service, PJI9 (See Appendix A). Consent by the child, parent(s) and/or others with parental responsibility will be required.

7.8 The referral will need to include the following information:

- the charges against the defendant;
- the relationship between the defendant and the witness or whether the charges involve an abuse of trust;
- the defendant's custody status and any change in this during the pre-trial period; and
- matters which may affect how preparation is conducted or how the witness gives evidence. (Achieving Best Evidence paragraph 4.22).

THE YOUNG WITNESS SERVICE MUST NOT BE GIVEN DETAILS OF THE CASE OR THE EVIDENCE OF THE WITNESS.

7.9 The key components of the Young Witness Service include:

- assessing the child's needs in relation to a court appearance;
- helping the child to understand the court process and their role in it;
- taking the child to visit the court before the trial;

- providing the child with stress reduction and anxiety management techniques;
- involving the child's parent or carer;
- communicating information (including the child's wishes) to the Police, Public Prosecution Service and courts, keeping the child, parent or carer informed and ensuring that practical arrangements are made concerning the child;
- the possibility of accompanying the child while giving evidence; and
- debriefing the child witness and parent or carer when the case is over.

7.10 The Young Witness Service shall work within the guidelines detailed in Appendices F and J of "Achieving Best Evidence". (Appendix F: Court Witness Supporter in Close Circuit Television (CCTV) Link Room: National Standards; Appendix J: National Standards for Young Witness Preparation).

8 TRAINING AND DEVELOPMENT

Training, Support and Supervision

8.1 The investigation of allegations or suspicions of child abuse, involving the interviewing of children for evidential purposes, is a complex, specialised and emotionally demanding area of work requiring the highest standards from staff directly involved. In order to maintain and develop these standards staff engaged in this area of work need to be provided with training, at different levels, to equip them with the skills required to carry out the task.

It is the responsibility of each agency to ensure that staff are appropriately targeted to receive the necessary training and that they are supervised and supported by their managers. A process of Personal Development Review has been introduced for this purpose. (See proformas Appendix B).

Initial assessment and consultation process

8.2 No specialist training qualifications are required for staff involved in the initial assessment and consultation process other than that he/she should be conversant with the requirements of this Protocol for Joint Investigation.

8.3 Staff consulting with a child or children following a referral will do so only for the purpose of assessment and basic information gathering. Such actions should not be viewed as either a clarification discussion or an interview.

Joint Protocol Investigators

8.4 Persons will be considered qualified to investigate cases of alleged and suspected child abuse after having completed either of the following sessions of training:

- Completion of Joint Protocol training blocks 1 and 2; (pre 2002) or
- Module 1 Joint Investigators course.

8.5 Joint Protocol Investigator training will qualify the practitioner to carry out investigations up to the point of conducting a clarification discussion. Once a decision has been made that an investigative interview of a child should be conducted the matter will be passed to the interviewing team for necessary action.

Joint Investigative Interviewing Team

8.6 Video interviewing is very much a specialist role therefore the experience required and training provided must reflect the level of skills necessary. Interviewers must have the opportunity to practice in order to develop and maintain their skills.

8.7 The interviewing of children on videotape requires an interviewing team and only those who have completed the relevant training will carry out video recorded interviews with children. Persons will be considered qualified to carry out videotaped investigative interviewing of children having completed either of the following sessions of training:

- Completion of Joint Protocol training blocks 1 and 2 (pre 2002), plus video evidence training block 3 (pre 2002) plus the conversion course of 4 days duration or
- Module 1 Joint Investigators course plus Module 2 Specialist Interviewers course.

8.8 In order to ensure continuing competence members of interviewing teams must complete a minimum of 3 self-assessment and supervisors assessments using the PDR process in each 12 month period and undertake refresher training at least every 2 years.

Training for Managers

8.9 In order to supervise and support staff involved in conducting interviews with child witnesses it is important that managers are familiar with the standards required and are in a position to evaluate practice. Managers should receive training in the use of the Personal Development Review process.

GLOSSARY OF TERMS

ACHIEVING BEST EVIDENCE IN CRIMINAL PROCEEDINGS (NI)

This document replaces the Memorandum of Good Practice on video recorded interviews for child witnesses for criminal proceedings. The guidance provided is advisory and does not constitute a legally enforceable code of conduct. Each witness is unique and the manner in which they are interviewed must be tailored to their particular need and circumstances. However, interviewers and other practitioners should bear in mind that significant departures from the guidance may have to be justified in court.

AREA CHILD PROTECTION COMMITTEE:

An inter-agency forum in each Health & Social Services Board area whose function is to determine the strategy for safeguarding children and to develop and disseminate policies and procedures. (DHSS&PS Co-operating to Safeguard Children 2003).

AREA CHILD PROTECTION PROCEDURES:

A set of agreed inter-agency procedures and guidance produced by the ACPC for named professionals who may be required to report and respond to child protection concerns.

ARRAIGNMENT:

The point in formal criminal proceedings at Crown Court where the defendant is required to plead guilty or not guilty. The result of the arraignment will determine whether a criminal trial, involving witnesses, is required.

ARTICLE 18:

The Children (NI) Order 1995 requirement for Social Services, Boards and Trusts to provide support to children identified as being “in need”.

ARTICLE 66:

Social Services duty to investigate under the Children (NI) Order 1995. The Article requires Social Services to investigate instances where a child in its area is the subject of an Emergency Protection Order, Police Protection or is believe to be at risk of significant harm.

CHILD:

The Children (NI) Order 1995 describes a child as a person under the age of 18.

CHILD PROTECTION CASE CONFERENCE:

An inter-agency forum to consider risk to a child and decide whether or not a child's name should be placed on the Child Protection Register and to agree a Child Protection Plan.

CHILD PROTECTION REGISTER:

A register listing all children resident in each Trust area who are subject to a Child Protection Plan.

CHILD WITNESS:

There are several definitions of "child" for legal purposes. For the purposes of the Special Measures directions which may be made under the Criminal Evidence (NI) Order 1999 to assist eligible witnesses to give evidence, the child witness is a witness who is eligible because he/she is under 17 years of age when the direction is made.

Another relevant definition of a "child" for the purposes of the Criminal Evidence (NI) Order 1999 relates to the giving of unsworn evidence. The child under the age of 14 who is competent to give evidence does so without taking an oath or making an equivalent affirmation, ie; unsworn.

CIVIL PROCEEDINGS:

A case at civil law is normally one between private persons and/or

private organisations. Typically it will be about defining the rights and relations between individuals. (For example, applications by Trusts for Orders in respect of children).

CLARIFICATION DISCUSSION:

A discussion with a child witness, prior to investigative interview, to establish whether or not the child has anything to say about allegations or suspicions that have been raised. This discussion does not involve any questioning about the substance of the allegations.

CLEVELAND REPORT:

The report of a major Government Inquiry in 1988 which was instrumental in effecting change in child protection policy, particularly in the area of multi-agency working and training.

COMPELLABILITY:

The general rule is that if a witness is competent to give evidence they are also compellable. This means that the court can insist on them giving evidence.

COMPETENCE:

In criminal proceedings a person who is not competent may not give evidence. Article 31 and 32 of the Criminal Evidence (NI) Order 1999 provides that all persons are (whatever their age) competent to give evidence, the exception applies where a person is not able to understand questions put to him/her as a witness, and give answers which can be understood. A person over 14 years of age who is competent but who does not appreciate the significance of an oath give evidence unsworn, as do children under the age of 14.

CO-OPERATING TO SAFEGUARD CHILDREN 2003

Guidance issues by the DHSS&PS 2003 which replaces Volume 6 of the Children (NI) Order guidance and regulations, Co-operating to Protect Children.

CORROBORATIVE EVIDENCE:

Any evidence which supports or confirms the substance of the allegation. (For example; forensic or medical evidence).

CRIMINAL PROCEEDINGS:

A criminal case normally involves the trial of a person(s) by a jury for the alleged commission of an offence created by law.

CROSS-EXAMINATION:

The secondary stage of evidence giving in court where the testimony that a witness had already given is examined by counsel for the defence.

CROWN COURT:

The criminal court that tries those charged with serious offences, this includes offences which are triable on indictment such as rape.

DEFENDANT:

A person on trial in criminal proceedings.

EVIDENCE:

The term evidence embraces all matters exclusive of mere argument which can be placed before a court to support the argument for the prosecution or the defence in criminal cases or the applicant or respondent in civil cases.

EVIDENCE IN CHIEF:

The initial stage of giving evidence in court where the witness is taken through their evidence by counsel for the prosecution.

EXAMINATION IN CHIEF:

The procedure in a trial where the lawyer representing the side who has called the witness takes that person through his/her evidence.

FORENSIC MEDICAL OFFICER:

An independent medical practitioner who provides a forensic medical examination service to the Police for the purpose of criminal investigation. The examination will include the collection of evidential samples for analysis.

FORM 38/36

The form used for recording a statement of evidence.

HEARSAY:

Anything which a person heard from another person other than the accused.

ICIS (INTEGRATED CRIMINAL INFORMATION SYSTEM):

The Police Service of Northern Ireland computerised system for managing information relating to criminal activity, criminal records, persons and incidents.

INTERMEDIARY:

One of the Special Measures which the Criminal Evidence (NI) Order 1999 that allows for certain eligible witnesses to give evidence, (both examination in chief and cross-examination), through an intermediary. The intermediary may explain the questions to or answers from the witness to the extent necessary to enable them to be understood.

INTERVIEW:

A person in authority seeking to obtain information from another party through questioning.

INTERVIEW CONTROLLER:

One of the interviewing team, also referred to as the second interviewer, who has responsibility for the video recording of the interview and who will assist the lead interviewer in identifying gaps in the child's account or points to prove.

INTERVIEW SUITE:

A facility which has equipment meeting the required standards for interviewing in accordance with Achieving Best Evidence and the Criminal Evidence (NI) Order 1999.

INTERVIEW SUPPORTER:

A person included in an interview for the purpose of supporting a child witness, where considered necessary because of the child's age or their being distressed or upset. The interview supporter will have been instructed not to participate in the interview itself.

JOINT INVESTIGATION:

A child abuse investigation undertaken jointly by Police and Social Services and/or NSPCC.

LEAD INTERVIEWER:

The member of the interviewing team who has been deemed most suitable to conduct the video recorded interview with the child.

LIVE TELEVISION LINK:

One of the Special Measures provided by the Criminal Evidence (NI) Order 1999 whereby certain witnesses can give evidence from a television monitor in a room separate from the main body of the court.

LOOKED AFTER CHILD:

A child subject to a Care Order or accommodated by a Health & Social Services Trust.

MUNCHAUSEN SYNDROME BY PROXY:

A condition in which a child is used as a surrogate patient where the carer falsifies a history and may harm the child in order to seek medical care so that they appear to be deeply concerned and protective.

PAEDOPHILE:

An adult, usually male, who has a sexual preference for pre-puberty children. A paedophile may or may not have been convicted or suspected of a criminal offence.

PJI FORMS:

The inter-agency forms used by Police and Social Services to record the information relating to a joint investigation of allegations or suspicions of child abuse.

PSNI GENERAL ORDER:

Internal directions issued to the Police Service of Northern Ireland, in written form in response to legislative or procedural changes or to take cognisance of new policy.

PUBLIC PROSECUTION SERVICE:

A body of legal staff who work independently from the Police and who are responsible for the prosecution of criminal offences.

REGIONAL CORE GROUP:

A group representing the 4 Health & Social Services Boards, PSNI and NSPCC that has strategic responsibility for policies and procedures in respect of the Joint Investigation by Social Workers and Police Officers of alleged or suspected cases of child abuse.

SCHEDULE ONE OFFENCE:

List of offences that indicate a definite risk to children which are detailed in Schedule One of the Children and Young Persons Act 1968. (Currently under review).

SECTION 20:

The section of the Children and Young Persons Act 1968 which creates child specific offences under the heading cruelty. These offences include neglect, abandonment and ill treatment.

SINGLE AGENCY INVESTIGATION:

An investigation carried out by the agency with specific statutory responsibility for the issues arising in each case. Police – criminal offences and Social Services/NSPCC – child welfare.

SPECIAL MEASURES:

“Special Measures” is the term used in the Criminal Evidence (NI) Order 1999 and in Achieving Best Evidence to describe the range of new provisions aimed at facilitating the giving of best evidence by children and vulnerable witnesses.

SPECIALIST INVESTIGATIVE INTERVIEWER:

A Police Officer or Social Worker who has undergone training and is deemed competent to conduct forensic investigative interviews in accordance with Achieving Best Evidence.

STATEMENT OF EVIDENCE:

The formal written account of what a witness has perceived and certified as true and accurate by the witness. In child abuse investigations these statements will be taken by Police.

STATUTORY RESPONSIBILITY:

The duties and responsibilities placed on agencies through legislation.

STRATEGY DISCUSSION:

An early exchange of information between Police and Social Services with the objective of agreeing a strategy for the investigation usually conducted by telephone.

STRATEGY MEETING:

A face to face meeting involving representatives of both Police and Social Services with the objective of agreeing a strategy for the investigation.

THIRD PARTY MATERIAL:

Matters of potential relevance to a police investigation which are not in possession of police.

TRUST CHILD PROTECTION PANEL:

A multi-disciplinary forum comprising representatives from the key agencies with the remit of developing inter-agency co-operation in child protection at an operational level.

VICTORIA CLIMBIE INQUIRY:

Report produced by an Inquiry Team chaired by Lord Laming in February 2003 into the circumstances surrounding the death of 8 year old Victoria Climbie in January 2000.

VIDEO RECORDING:

According to Article 15 of the Criminal Evidence (NI) Order 1999, “video recording” means any recording on any medium, from which a moving image may by any means be produced, and includes the accompanying soundtrack.

APPENDIX A

FORMS

PJI 1	CONFIRMATION OF REFERRAL OF ALLEGED OR SUSPECTED ABUSE TO POLICE OR SOCIAL SERVICES
PJI 2	INITIAL STRATEGY FOR INVESTIGATION
PJI 2(a)	AMENDMENTS TO STRATEGY FOR INVESTIGATION
PJI 3	CHILD WITNESS CLARIFICATION DISCUSSION
PJI 4	PLANNING THE JOINT INVESTIGATIVE INTERVIEW OF THE CHILD
PJI 5	INDEX TO VIDEO RECORDED INTERVIEW
PJI 6	CONSENT FOR MEDICAL EXAMINATION
PJI 7	DECISION TO END THE JOINT PROTOCOL PROCESS/INVESTIGATION

APPENDIX B

Part 1	SELF APPRAISAL OF VIDEOTAPED INVESTIGATIVE INTERVIEW
Part 2	SUPERVISOR’S EVALUATION OF VIDEOTAPED INVESTIGATIVE INTERVIEW

APPENDIX C

NSPCC CHILD WITNESS REFERRAL FORM

PJI 1

CONFIRMATION OF REFERRAL OF ALLEGED OR SUSPECTED ABUSE TO POLICE OR SOCIAL SERVICES

(To be completed by agency making the referral)

Referral by telephone on _______/_______/________
To: ________________________________ Designation: ____
Person referring: ____________________ Designation: ____
Address: ____

Contact Telephone Number: ____
Child's Name: ____
Date of Birth: ____
Home Address: ____
____

Present Location: ____

Details of any current Court Orders/Police protection: ____
____

Details of any current or past involvement with Social Services or Police including the Child Protection Register: ____
____
____

Name of parent/person with parental responsibility: ____
Address:____
____

Telephone Number: ____

Alleged Perpetrator: ____

Background details of the referral - details of alleged or suspected abuse: _________________________
____
____
____
____
____
____
____
____
____
____

Signature: ____ Date: _____________________________

PJI 1 (Continued)

OUTCOME OF INITIAL ASSESSMENT

Action Decided:

☐ No Further Action *

☐ Family Support *

☐ Police Only Investigation *

☐ Duty to Investigation (Article 66) *

☐ Joint Investigation

* If this is the end of the Joint Protocol process a PJI 7 must be completed in this case.

Signature: ______________________________ Date: ____________________

Original for Police file and copy for Social Services records

PJI 2

INITIAL STRATEGY FOR INVESTIGATION

Child's Name: ________________________________ D.O.B: ______________________

(A) CONSULTATION GP HV School
Other(s) specify: ______________________

(B) STRATEGY DISCUSSION: Telephone/Meeting * Date: ______________________

Persons Involved/Designation:

______________________ ______________________
______________________ ______________________
______________________ ______________________

Agreed Action:

____
____
____
____
____
____

(C) PERSONS TO BE INTERVIEWED

1. Person making the allegation to clarify all facts about the referral

Name(s): ________________________________
By Whom:
Social Worker: ______________ PSNI: ______________________ ☐

2. Parent's/person with parental responsibility or other carers

Name(s): ______________ ______________
Relationship to child: ______________ ______________
By Whom:
Social Worker: ______________ PSNI: ______________________ ☐

3. Other family members/Significant Others

Name(s): ______________ ______________
Relationship to child: ______________ ______________
By Whom:
Social Worker: ______________ PSNI: ______________________ ☐

* Delete as appropriate

PJI 2 (Continued)

4. The Child

Name: ____
By Whom:
Social Worker: ________________ PSNI: _________________ ☐

5. Siblings

Name(s): ______________________ ________________________
______________________ ________________________
______________________ ________________________
By Whom:
Social Worker: ________________ PSNI: _________________ ☐

6. The Alleged Abuser(s)

Name: ___________________________________ D.O.B: _________________
Name: ___________________________________ D.O.B: _________________
Relationship to Child: ____
By Whom:
Social Worker: ________________ PSNI: _________________ ☐

HAS A COMPLAINT BEEN MADE ? Yes/No

MEDICAL EXAMINATION

Is a medical examination considered appropriate? Yes/No

Date: _____________ Venue: ____

To be conducted by: (Tick as appropriate)

- ☐ Joint - FMO/Paediatrician
- ☐ FMO
- ☐ Paediatrician
- ☐ Other
- ☐ Medical examination already completed By Whom: ____________________

Completed by: ___________________________ Date: ______________________
(Senior Social Worker)

Agreed by: _____________________________ Date: ______________________
(Police Officer)

One PJI 2 per alleged victim

Original for Police file and copy for Social Services records

PJI 2(a)

AMENDMENTS TO STRATEGY FOR INVESTIGATION

Child's Name: ____ D.O.B: ______________________

Agreed amendments to strategy: ____

____

____

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Remember to indicate if this is the end of the Joint Protocol process/investigation and complete a PJI7.

Completed by: ____ Date: ________________________
(Senior Social Worker)

Agreed by: ____ Date: ________________________
(Police Officer)

Original for Police file and copy for Social Services records

PJI 3

CHILD WITNESS CLARIFICATION DISCUSSION

(Responsibility for completion rests with either Police or Social Services)

(The purpose of this discussion is to assess the child's willingness and ability to participate in an investigative interview)

Name of child: ______________________________ D.O.B:____________________________
Venue:____

Date:__________________Time:__________________

Persons present: Designation/Relationship:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

If the child has not made a clear disclosure of abuse or there are no substantive grounds for suspecting abuse has occurred a clarification discussion should not be undertaken.

CONSIDERATIONS

1. Is the child willing to engage in an investigative interview? Yes/No

Comment: ____
____

2. Is the child able to engage in an investigative interview? Yes/No

Comment: ____
____

3. Has the purpose of the investigative interview been explained to the child? Yes/No

Comment: ____
____

4. Is the child willing to pursue the matter through the police and eventually to court? Yes/No

Comment: ____
____
____
____
____
____

PJI 3 (Continued)

5. Which is the most suitable format for the interview for this child?

- ☐ VIDEO
- ☐ WRITTEN STATEMENT
- ☐ QUESTION AND ANSWER

6. If a video interview appears to be the most appropriate option assess the child's willingness to be interviewed on video tape. Where the preferred option is not video interview give reasons.

____
____
____

RECORD OF DISCUSSION
(IF, DURING THE DISCUSSION, THE CHILD SPONTANEOUSLY DISCLOSES EVIDENCE OF ABUSE A CONTEMPORANEOUS, VERBATIM RECORD MUST BE MADE).

____

If this is the end of the Joint Protocol process/investigation please indicate and complete PJI 7.

Person making notes: ______________________

Original for Police file and copy for Social Services records

PJI 4

PLANNING THE JOINT INVESTIGATION INTERVIEW OF THE CHILD
(To be completed by Joint Investigative Interviewers)

Child's Name: ____ D.O.B: ______________________

Those undertaking an investigative interview with a child should, at the planning stage, take account of the checklist of factors to be considered. (Achieving Best Evidence paragraphs 2.45 through to 2.62).

Do any special considerations apply? ____
____
____
____
____
____
____
____
____

Interpreter/Intermediary * Yes/No

If yes, Name, Grade/Qualification:____

Interview Supporter: Yes/No

If yes, Name: ____

Relationship: ____________________________________

How will the parent(s)/carer(s) be informed about the outcome of the interview, when and by whom?
____
____
____
____

* Delete as appropriate

Original for Police file and copy for Social Services records

PJI 4 (Continued)

Detail specific arrangements planned for the interview (*Who, What, When, Where, How)*

Name: ____ Date: ________________________
(Joint Investigative Interviewer - Police Officer)

Name: ____ Date: ________________________
(Joint Investigative Interviewer - Social Worker)

Original for Police file and copy for Social Services records

PJI 5

INDEX TO VIDEO RECORDED INTERVIEW

(To be completed by the interviewer controlling the investigative interview)

Number of pages:____

Child Interviewed: ____

Place of Interview: ____

Date of Interview: ____

Time Commenced: ____________________ Concluded:____________________

Duration of Interview: ____

Interviewer controlling the interview:______________________________

Other persons present: ____

Relationship to child:____

Number of audio tapes used: ____________________________________

Number of video tapes used: ____________________________________

Evidential seal number(s): ______________________ Unique ref no: __________

Location of storage of master tape: ________________________________

Person in possession of working copy: ________________________________

Date of audio tape transcript: ____________________________________

By whom transcribed: ____

The form overleaf should be used to record the details of the interview (use additional pages as necessary).

The following details should be recorded using the child's own words where practicable.

Use three headings - Child's description of:

(1) Offence (2) Offender (3) Information relevant to date of offence

Original for Police file and copy for Social Services records

PJI 5 (Continued)

Child's Name: ______________________________ Date of Interview: ________________

Page No:

Tape Counter Times	Person Speaking	Text

PJI 6

CONSENT FOR MEDICAL EXAMINATION

(Responsibility for ensuring completion rests with the Doctor)

Child/Young Person's Name: ______________________________ D.O.B: ______________

Doctor

I confirm that I have explained the purpose and implications of this medical examination, which may include the taking of photographic evidence, in terms which in my judgement are suited to the understanding of the child/young person. I have also explained the medical examination to a parent or person with parental responsibility for the child/young person.

Signature(s): ____

Name of Doctor(s): ____

Date: ___________________________________

Parent/Person with Parental responsibility

I consent to the medical examination of ____,

the purpose of which has been explained to me by the Doctor.

Signature: ____ Date: ________________________________

and/or

Child

I consent to a medical examination the purpose of which has been explained to me by the Doctor.

Signature: ____ Date: ________________________________

Original for Police file and copy for Social Services records

PJI 7

DECISION TO END THE JOINT PROTOCOL PROCESS/INVESTIGATION

(To be completed by a Social Work Manager/PSNI Police Officer responsible)

Child's Name: ______________________________________ D.O.B: ____________________________

Address: ____

____

____

____

Outline the reasons for ending the Joint Protocol process at this stage

____

____

____

____

____

Agency representatives making this decision:

Name: ____________________________ PSNI

Name: ____________________________ Social Services

Signature: ____

Designation: ______________________________________

Original for Police file and copy for Social Services records

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APPENDIX B - Part 1

SELF APPRAISAL OF VIDEOTAPED INVESTIGATIVE INTERVIEW

Name of interviewer ____

Designation: Social Worker_______________ **Police Officer** ____________________

Training month and year ____________________________

Number of videotaped investigative interviews completed _______________________

Name of interview controller ____

Designation: Social Worker_______________ **Police Officer** ____________________

Training month and year ____________________________

Age of child witness________________ **Gender** ________________

Length of interview in minutes _______________________________

Instructions

Having completed an investigative interview on videotape in accordance with the Joint Protocol and 'Achieving Best Evidence' guidelines the interviewer should carry out the following appraisal of their own performance. Prior to carrying out the self appraisal the interviewer should discuss the interview with the controller.

The interviewer should view the whole of the videotape in private then use the following guide in commenting on performance in the current interview:

Very Good	**Covered well or not applicable**
	Reasonably well covered but improvement possible
Satisfactory	**Adequately covered to minimum acceptable standard**
	Inadequately covered and improvement necessary
Poor	**Not covered at all: poorly done or poorly timed**

Technical aspects *** Delete as appropriate**

Sound

Sound quality of interviewer's voice	**Poor / Satisfactory / V. Good***
Sound quality of witness's voice	**Poor /Satisfactory / V. Good***
Background noise	**Unacceptable / Acceptable***

Picture

Picture quality	**Poor / Satisfactory / V. Good***
Witness's face seen clearly throughout	**Yes / No**

Resources

Appropriate use made of:

Drawing materials	**Yes / No***
Toys/Puzzles/Lego blocks etc.	**Yes / No***
Dolls	**Yes / No***
Show and tell dolls	**Yes / No***

In hindsight is there anything that could have been done better to prepare for the interview?

Phase 1 RAPPORT

Time started ______________________________________

Appraise performance in each of the following:
Introduction Poor / Satisfactory / V. Good*
Explanation of role Poor / Satisfactory / V. Good*
Reason for interview Poor / Satisfactory / V. Good*
Cameras pointed out to witness Yes / No*
Explanation of possible use of tape in court Yes / No*
Explanation of ground rules in interview Poor / Satisfactory / V. Good*

Was the following information obtained on videotape?
Date and Time of interview Yes / No*
Place of Interview Yes / No*
Child's name Yes / No*
Child's address Yes / No*

Were appropriate rapport subjects/topics used, eg.
Favourite activity, Favourite TV Programme, Favourite Game Yes / No*

Was the child asked if they agreed to proceed with the videotaped interview?
Yes / No*

Were the following issues addressed with the child?
Importance of telling the truth Yes / No*
Gain assurance from the child to tell the truth Yes / No*
Asks the child the difference between truth and lies Yes / No*
Mentioned the acceptability of saying "I don't know" Yes / No*
Was the alleged offence or offender mentioned? Yes / No*
Did the interviewer tell the child that he/she does not know what happened?
Yes / No*

Interviewer's use of vocabulary Poor / Satisfactory / V. Good*
Pauses used Yes / no*

Comment on whether rapport was established and how it connected into the next part of the interview ____
____
____
____

Time rapport phase ended _______________________ Duration ___________________

Phase 2 **FREE NARRATIVE**

Time started ____________________________

Appropriate use made of open phrases or questions solely as prompts
Poor / Satisfactory / V. Good*

Inappropriate interruptions of witness
Yes / No*

Use of pauses **Poor / Satisfactory / V. Good**

Use of verbal utterances to indicate interest (e.g. "Ah, uh")
Poor / Satisfactory / V. Good

Use of verbal continuances (e.g. "and then what?")
Poor / Satisfactory / V. Good

Use of verbal summaries to affirm information
Poor / Satisfactory / V. Good

Witness reassurance
Poor / Satisfactory / V. Good*

Summary of information disclosed
Poor / Satisfactory / V. Good*

If interview continued, what disclosure warranted further questioning?
____
____
____
____

What prompted end of Free Recall?
____
____
____
____

Time free narrative ended ________________________ Duration _____________________

Phase 3 QUESTIONING

Time started ______________________________

Use of open ended questions (e.g. Tell me what happened?)
Poor / Satisfactory / V. Good*
Use of specific but non-leading questions (e.g. When did …….happen?)
Poor / Satisfactory / V. Good*
Use of closed questions (e.g. Did that happen more than once?)
Poor / Satisfactory / V. Good*
Were leading questions used (e.g. Was it Fred who was there?)
Yes / No*
Use of verbal prompts/continuances (e.g. "Ah, uh, huh" etc.)
Poor / Satisfactory /V. Good*
Use of non-verbal continuances (e.g. nods, head shakes, facial expressions etc.)
Poor / Satisfactory / V. Good*
Use of rhetorical questions and affirmations
Poor / Satisfactory / V. Good*

Descriptive information obtained:
Details of persons involved Yes / No*
Details of when incident occurred Yes / No*
Details of exactly what happened Yes / No*
Details of where the incident occurred Yes / No*
Details of how the witness got there Yes / No*
Male sexual parts Yes / No*
Female sexual parts Yes / No*
Touch sensations (Pain etc.) Yes / No*
Feelings (How did that feel?) Yes / No*
Motor vehicles (if applicable) Yes / No*

Did questions graduate from general to specific Yes / No*
Interruptions of witness Inappropriate / Appropriate
Use of multi-part questions Inappropriate / Appropriate
Clarification of witness terminology Poor / Satisfactory / V. Good
Was a clear account of the alleged incident obtained Yes / No*
Was witness fluent Yes / No* Anxious Yes / No* Tearful Yes / No*
Eye contact Poor / Satisfactory / V. Good
Comfort offered Inappropriate / Appropriate
Consultation with interview controller Poor / Satisfactory / V. Good

How was questioning phase brought to an end?
____
____
____

Time ended ___________________________ Duration ______________________________

<u>Phase 4</u>   <u>CLOSURE</u>

Time started ________________________________

Reason for closure of interview?

____
____
____
____

Explanation given for termination of interview   Yes / No*

Was information summarised and affirmed with witness   Yes / No*

Opportunity offered to provide further information   Yes / No*

Witness reassured   Poor / Satisfactory / V. Good*

Witness given opportunity to ask questions   Yes / No*

Answers given to witnesses questions   Poor / Satisfactory / V. Good*

Explanation of what happens next   Poor / Satisfactory / V. Good*

Neutral topics used again at closure   Poor / Satisfactory / V. Good*

Witness thanked?   Yes / No*

Contact name and telephone number provided   Yes / No*

Witness reminded of purpose of video   Yes / No*

Comments:

____
____
____
____
____
____
____

PERSONAL DEVELOPMENT

Now identify the three main strengths of your performance in this interview

1.____

2.____

3.____

Identify three areas of your performance needing further development

1.____

2.____

3. ____

From the information gathered in this self appraisal and in preparation for supervisor's evaluation, identify three Priority Objectives for your performance development. ***(The objectives must be specific, measurable, achievable and realistic.)***

1.____
____
____

2. ____
____
____

3. ____
____
____

Comments

____
____
____

These forms along with the interview video-tape should now be handed to your supervisor in a sealed envelope marked "Videotaped Investigative Interview - Interviewer Self Appraisal".

Date completed ____________________ **Time completed** ________________

Signed ______________________________________

APPENDIX B – Part 2

SUPERVISOR'S EVALUATION OF VIDEOTAPED INVESTIGATIVE INTERVIEW

Name of Supervisor ____

Designation ____

Name of interviewer ____

Designation: Social Worker______________________ **Police Officer** ______________________

Length of interview in minutes ____

Supervisor should consider the Interviewers Self Appraisal before carrying out this evaluation

Instructions

The supervisors should carry out the following evaluation whilst viewing the video tape of the interview.

This document is a Behaviourally Anchored Rating Scale (BARS) and has been designed for the assessment of investigative interviews of children. At first sight the size of the rating scale may seem enormous and impractical to administer. In fact there are only eight areas or dimensions to be assessed. The bulk of the information consists of example behaviours to help you conduct the assessment. It is important to remember that the behaviours provided in the BARS are only examples and not an exhaustive list.

Space is provided for insertion of notes of evidence. The score you insert at the bottom of each dimension is suggested score rather than a final one. The final score should only be inserted following consultation and discussion with the interviewer.

It should also be remembered that not all of the behaviours described will be present or necessary for every interview. Whatever suggested score is inserted must be evidenced in the form of examples from the interview. It is only in this way that the score can be justified and more importantly you con provide feedback with supporting evidence.

Before starting the assessment it is strongly recommended that you read through the BARS at least once to familiarise yourself with the dimensions and their example behaviours. This will make the scale much easier to use.

(Rate on a scale of 1 - 7 with 1 being POOR and 7 being VERY GOOD)

Phase 1 Rapport

Example Behaviours	Scale	Evidence
Interviewer fully involved the child in friendly conversation. Used knowledge of child gathered in planning stage to establish a good rapport.	7	Tape/Time
Interviewer involved the child in conversation and made use of child's favourite activity/TV programmes etc. to establish rapport. Child reacted positively.	6	
Interviewer asked the child a number of questions about favourite activities/TV programmes etc. in an attempt to establish rapport. Child showed willingness to answer.	5	
Interviewer asked the child a number of questions about various things in an attempt to establish rapport but the child appeared uneasy and failed to answer.	4	
Interviewer talked to the child but failed to give child opportunity to respond.	3	
Interviewer attempted to establish rapport in a false and confusing way.	2	
Interviewer makes no attempt to establish rapport with the child but begins by introducing subject of interview.	1	Score:

Phase 2 Free Narrative

Example Behaviours	Scale	Evidence
Interviewer makes good use of silence along with verbal and non-verbal continuances to encourage child to speak freely. Interviewer uses verbal summaries to affirm information and to reassure the witness without unnecessary interruptions.	7	Tape/Time
Interviewer makes proper use of prompts and pauses to enable child to speak without interruption. Summarises what child has already said.	6	
Interviewer makes use of prompts without interrupting childs narrative.	5	
Interviewer attempts to use only open questions as prompts but uses other types of questions to encourage child to continue to speak.	4	
Interviewer attempts to use prompts and pauses but continue to speak every time the child stops speaking.	3	
Interviewer attempts to use prompts and pauses and to ask only open-ended questions as prompts, but continually interrupts child. Makes no attempt to confirm what the child is saying.	2	
Poor use of silence, prompts and pauses and improper use of open-ended questions. Numerous interruptions of childs account.	1	Score:

Phase 3 Questioning

Example Behaviours	Scale
Interviewer makes good and progressive use of open questioning, specific nonleading questions and closed questions sing pauses, verbal and non-verbal continuances to encourage child to speak freely without suggestion being made to the child and without unnecessary interruptions. Detailed examination of topics, obtaining relevant information.	7
Uses part of the information provided by the child and adapts questioning style in accordance with responses.	6
Appropriate use of questions the majority of which were relevant and focused on the investigation.	5
Limited use of open questions therefore limiting the answers to confined areas.	4
Questions are unclear. Superficial exploration of the childs account. Use of only closed questions.	3
Questioning is inappropriate, superficial and shallow. Some leading/multiple questions asked.	2
Does not use any open questions. Uses leading/ multiple questions. Questioning not relevant to information supplied by child.	1

Evidence

Tape/Time

Score:

Phase 3 Points to Prove

Example Behaviours	Scale	Evidence
Questioning results in full and clear identification of childs allegation and fully covers all points to prove and possible responses of accused.	7	Tape/Time
Identify of childs allegations and some covering of the points required to prove same.	6	
Questioning results in identification of childs allegations but does not cover all the information needed to prove them.	5	
Interviewer obtains a clear disclosure from the child but fails to obtain relevant details.	4	
Interviewer shows only a superficial knowledge and understanding of the points to prove and possible lines of defence.	3	
Interview results in only a very limited amount of descriptive information being obtained.	2	
Interviewer demonstrates no knowledge of points needed to prove alleged offence. The descriptive information obtained is limited and of little value.	1	
		Score:

Phase 3 Listening Skills

Example Behaviours	Skills
Interviewer allows child to respond freely to sequentially structured questions without interruption and then summarises accurately what the child has said.	7
Encourages the child to take time, think carefully and make multiple attempts at recall.	6
Recognises inaccuracies and vagueness in the account given by the child and asks further questions appropriately.	5
Asks too many questions obtaining a limited account from the child.	4
Does not summarise at appropriate points and does not recognises the value of childs responses to develop next question.	3
Fails to hear or ignores some of childs answers and does not recognise that the child has provided answers to the same question repeatedly.	2
Interrupts the child consistently whilst he/she is speaking. Ignores or fails to recognise inaccuracies in the account given by the child. Inaccuracies summarises information provided by child and ignores childs responses.	1

Evidence

Tape/Time

Score:

Phase 4 Closure

Example Behaviours	Scale	Evidence
Interviewer fully and clearly explains reason for closing the interview, summarises the information provided and gives the child opportunity and time to correct, alter or add to the information provided. Finishes interview on a positive note.	7	Tape/Time
Interviewer explains reason for closing the interview and summarises the information the child has provided but does not give child opportunity to ask questions etc. Reassures the child positively.	6	
Formal compliance with Memorandum guidance only.	5	
Provides child with explanation for closing the interview and of what will happen next. Does not give child opportunity to ask questions.	4	
Provides child with only a limited explanation of the reason for closing the interview and with no information of what is to happen next.	3	
Closes the interview without explanation what will happen afterwards.	2	
Abruptly ends the interview without giving explanation to the child.	1	
		Score:

Interviewing Style

Example Behaviours	Scale	Evidence
Conducts the interview using language etc. clearly appropriate to childs age and stage of development. Uses other equipment including dolls with confidence. Displays a professional, enthusiastic and confident approach throughout the interview using varying intonation and influence.	7	Tape/Time
Interviewer avoids use of difficult language, technical jargon and concentrates on matters relevant to investigation in a professional way. Makes some use of other equipment.	6	
Although displays confidence and enthusiasm interviewer uses language and jargon, which is not appropriate for the childs age or stage of development. No use of toys or other interview aids.	5	
A very formal or informal approach to the interview which does not display professionalism or confidence.	4	
Interviewer uses technical jargon and a monotone and stilted delivery style.	3	
Interviewer loses concentration and conducts the interview in an uninterested manner.	2	
Interviewer adopts a defeatist attitude to the interview process giving up when the child refuses to answer a question.	1	Score:

<u>Technical aspects</u>

Sound

Sound quality of interviewer's voice ____
Sound quality of witness's voice ____
Background noise ____

Picture

Witness's face seen clearly throughout **Yes / No**

Resources

Appropriate use made of:

Drawing materials	**Yes / No***
Toys/Puzzles/Lego blocks etc.	**Yes / No***
Dolls	**Yes / No***
Show and tell dolls	**Yes / No***

<u>Overall Supervisor's Evaluation</u>

This should be completed following analysis of the 'Interviewer's Self Assessment' and discussion with the interviewer about his/her performance.

Points scored in Introduction Phase _______

Points scored in Rapport Phase _______

Points scored in Free Narrative Phase _______

Points scored in Questioning Phase _______

Points scored in Points to Prove _______

Points scored in Listening Skills _______

Points scored in Closure Phase _______

Points scored for Interviewing Style _______

Calculate average points scored to identify overall performance score ________

Interviewer's comments: Agreed with evaluation / Disagreed with evaluation*

____
____
____

Signed ______________________________ **Date** __________________

APPENDIX C

Witness Support

Referral Form

☐ NSPCC Young Witness Service

☐ Victim Support Witness Service

Please contact relevant witness support service before making a referral using this form.

NB The person referred will have open access to the completed referral .

Completed forms should be sent to the relevant address set out on page 5 of this form.

Witness Details

Forename:	Surname:
Home Address:	D.O.B:
	Male / Female:
	Ethnicity: (see page 3)
Telephone No.	First Language:
Mobile:	Religion:
Daytime:	Details of Any Disability or Special Needs:
Evening:	
School:	Is the witness the injured party? **Yes / No** Has the witness agreed to the referral? **Yes / No**

Referrer

Name: Rank: No:	
Address:	
Telephone No	
Fax No:	
Alternative Officer:	
Police Case File No:	

Carer

Person with parental responsibility/guardianship Parent ☐ Guardian ☐ Not applicable ☐	
Has the person(s) with parental responsibility/guardianship agreed to the referral?	**Yes / No**
Is the current carer aware of the referral?	**Yes / No**

Other Witnesses

Are there any other Vulnerable Witnesses in this case?
Yes / No

If Yes Provide Details:

Defendant

Name:	
Relationship to Witness:	
Current Whereabouts: Custody Yes/No Bail Yes/No	Prison/General area:
Charge:	
Date of alleged offence:	
Likely venue of Court:	**Magistrates/Crown/Juvenile**
Date (if known):	
Bill No (if known):	
Defence Solicitor's Name and Address:	

Evidence

Video ☐ Statement: ☐ Date made ____________________

Special Measures Applied For? **Yes** / **No** (Please tick all appropriate boxes)

☐ Screens
☐ TV live link
☐ Evidence in private
☐ Removal of wigs and gowns
☐ Video recorded interview
☐ Video recorded cross examination
☐ Examination through intermediary
☐ Communication aids
☐ Mandatory protection from cross examination by accused
☐ Discretionary protection from cross examination by accused in person
☐ Restrictions on evidence and questions about the complainant's sexual history

Social Services Involvement

Name of Social Worker:	
Address and Telephone Number:	
Is the Witness on a Child Protection Register? If Yes, Category:	**Yes/No**
Is the Witness Subject of any Court Order? Yes, provide details.	**Yes/No**

Other Agency Workers

Agency Name	Name of Worker	Designation	Address	Telephone Number	Fax Number

Relevant Background Information (to include family details, how the witness may be coping with the situation, does this witness have any special needs? Any social work or therapeutic involvement?) **Do Not Include Any Details of Evidence**

____

____

____

____

____

____

____

Ethnicity Options
1. Caucasian
2. Asian
3. Afro-Caribbean
4. Oriental
5. Traveller
6. Other Specify

____

Signature: ______________________ **Date:**______________

<u>Referral Addresses</u>

<u>Young Witness Service</u>

NSPCC Young Witness Service
Antrim Courthouse
30 Castle Way
ANTRIM
BT41 3AQ
Telephone Number: 028 94 487533
Fax Number: 028 94 487590

<u>Vulnerable Adult Witness Service</u>

Miss Fiona Green
Witness Support Service
Victim Support
Annsgate House
BELFAST
BT1 4EH
Telephone Number: 028 90 244039
Fax Number: 028 90 313838

Area Child Protection Committees'

REGIONAL POLICY AND PROCEDURES

You can access this document in English, in large print, on 3½ inch computer disk, on our website: www.childrensservicesni.co.uk and at the websites for each Health & Social Services Board listed on the last page, and in other formats if you ask us.

We can also translate this report into Urdu, Bengali, Cantonese, Hindi, Punjabi and Irish, if you ask.

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.

Theresa Nixon

Chair of the Eastern Area Child Protection Committee

Margaret Black

Chair of the Northern Area Child Protection Committee

Tony Rodgers

Chair of the Southern Area Child Protection Committee

Dominic Burke

Chair of the Western Area Child Protection Committee

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

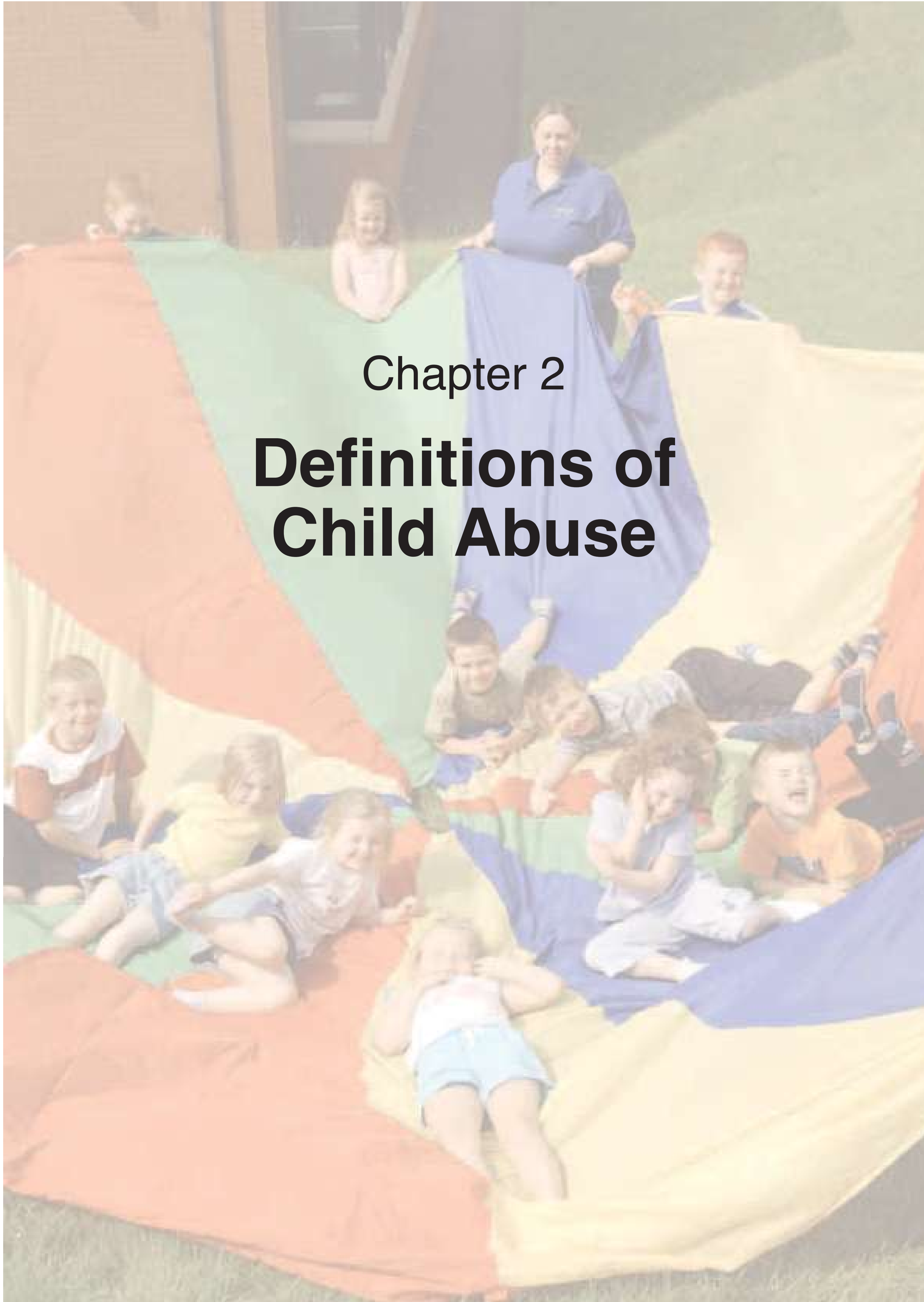
1.19 It is necessary to ensure that each agency's confidentiality policy is clearly understood by all involved. This includes those situations where information must be shared with others in the interests of a child's safety and the reasons why. It is equally important that each agency has a mutual understanding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

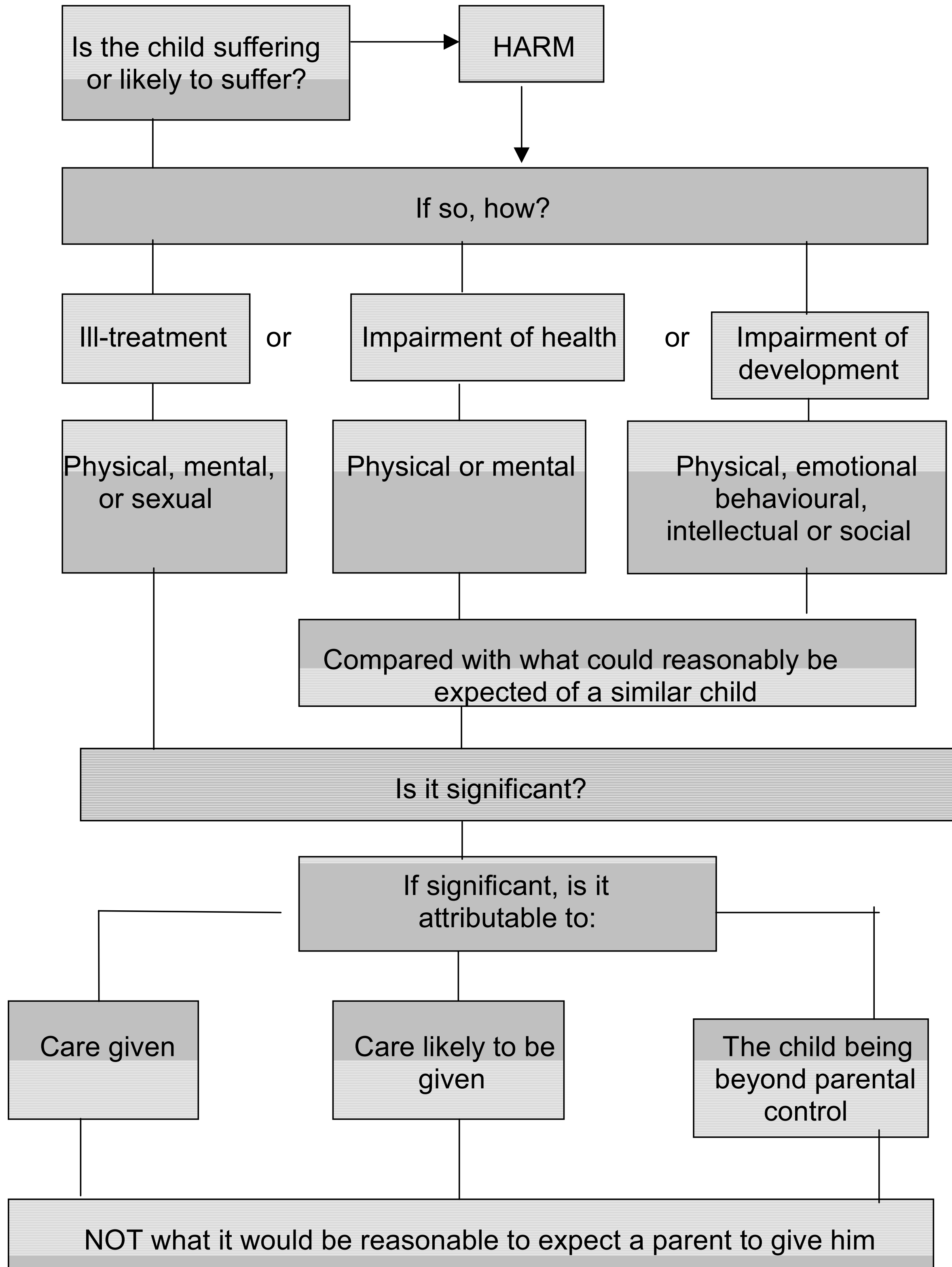
2.7 Harm is defined in the Children Order as "ill-treatment or the impairment of health or development". The Children Order definition of ill-treatment includes:

- 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

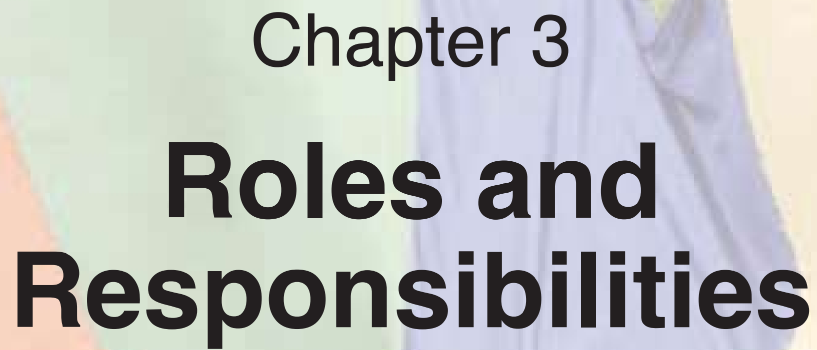
2.16 The recognition and identification of child abuse can be difficult and usually requires information from individual sources including detailed social and medical assessments. The final decision will be

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.

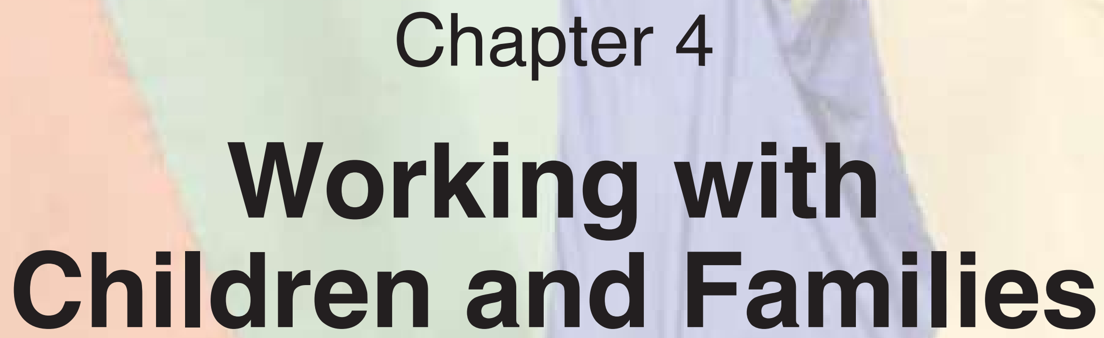
General Public

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.

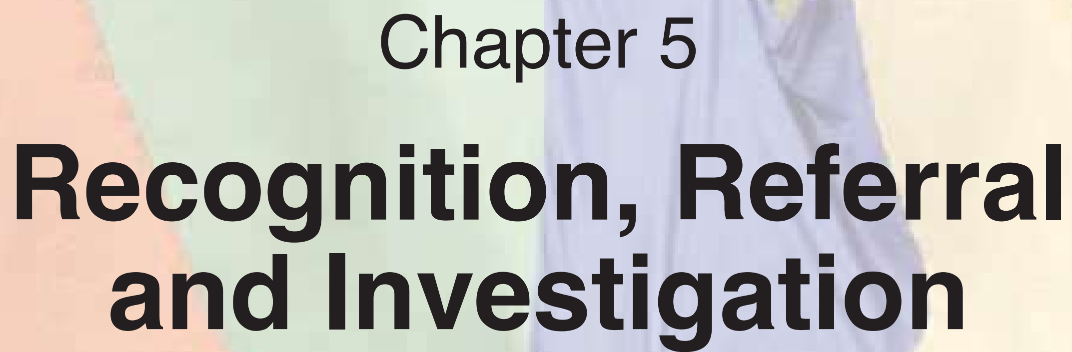
Family Group Conferences

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.

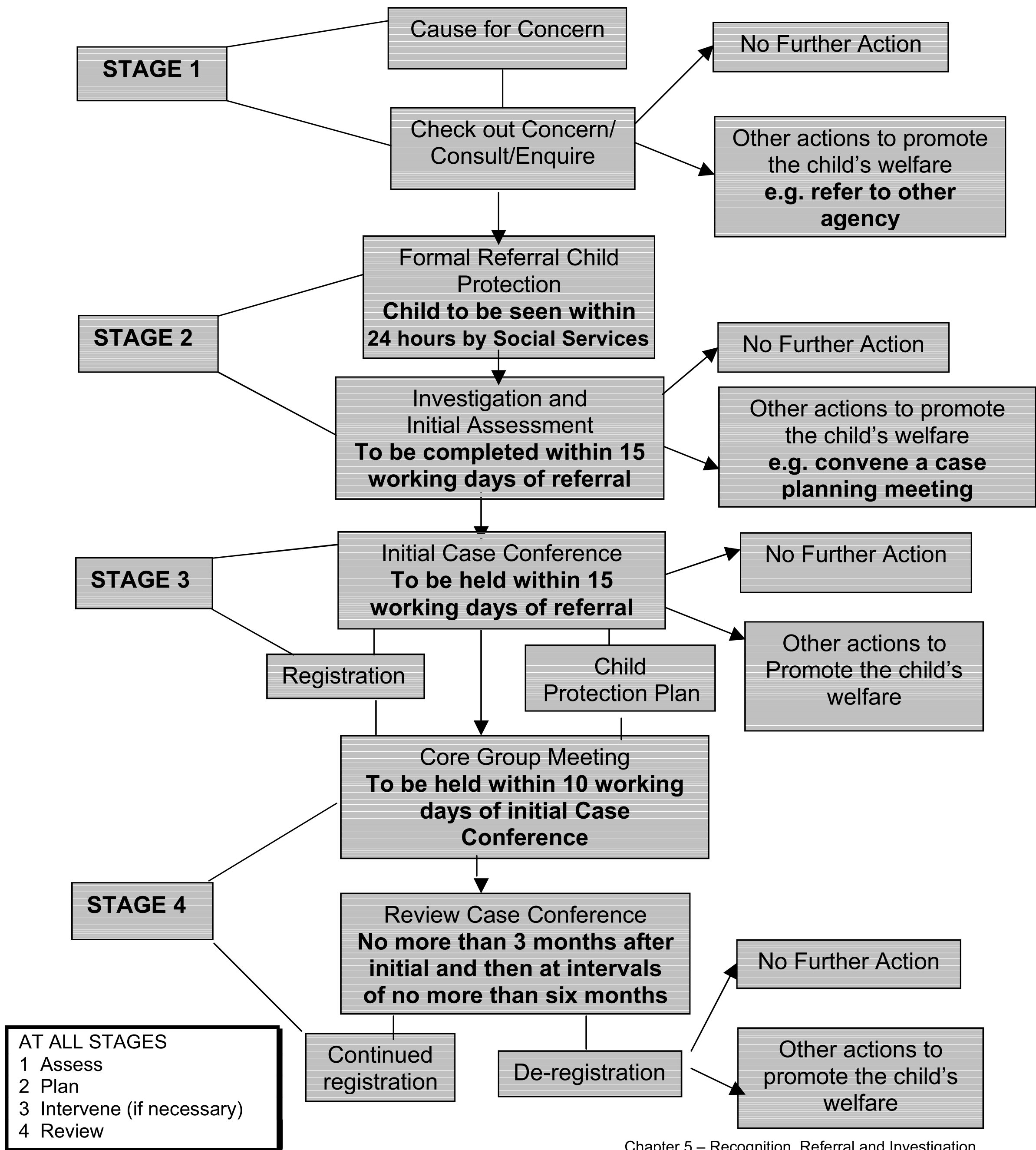


Chapter 5

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.

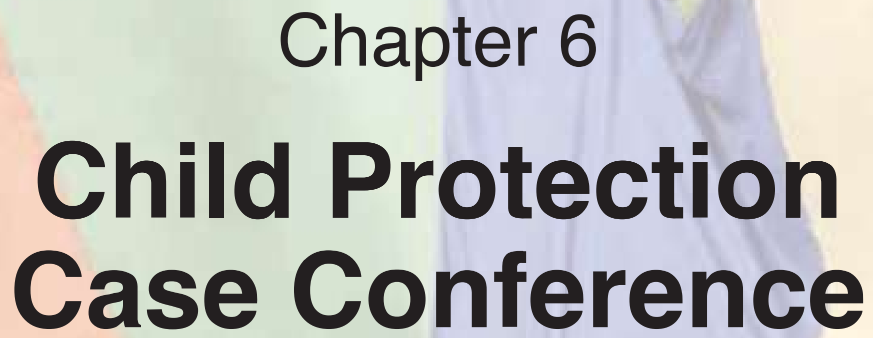
5.47 The Social Work Manager in the Family and Child Care Team

[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.

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- 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.

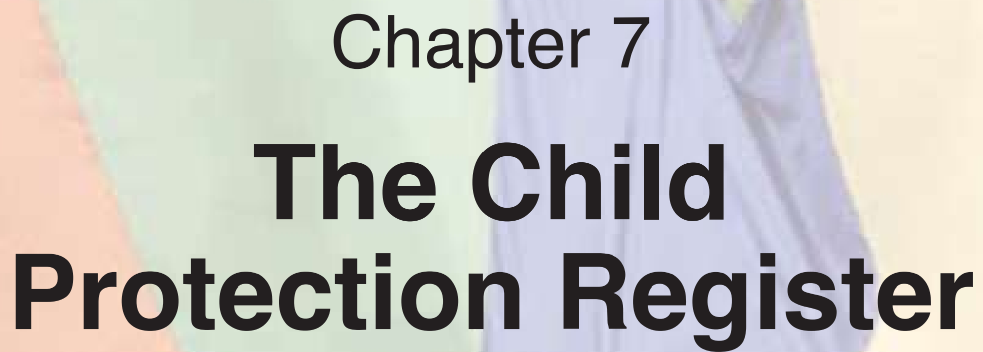
6.115 De-registration should not lead to the automatic withdrawal of support services. The child may still be assessed as a child in need under Article 17 of the Children Order. Any future support required by the child and family should be discussed at the review Child Protection Case Conference and 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

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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.

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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.

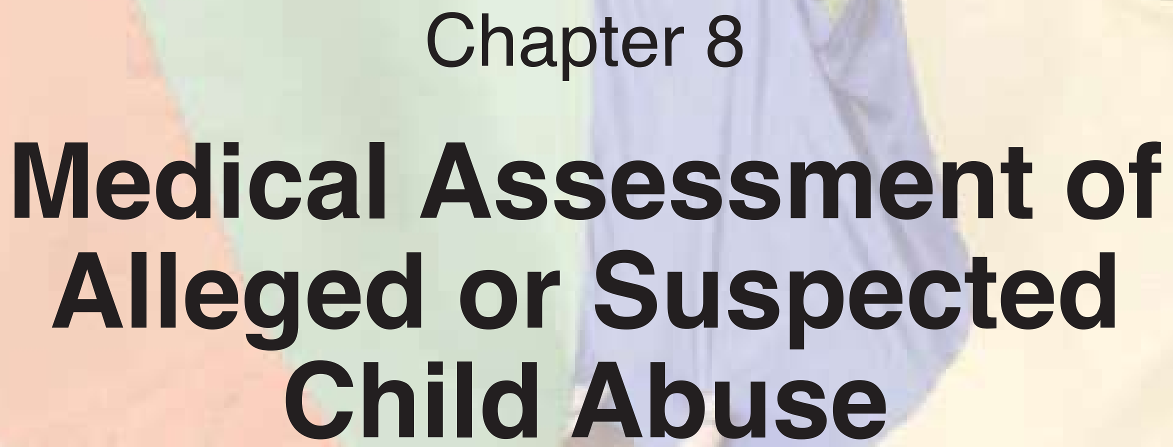
7.51 If the family is thought to be in the Republic of Ireland the Trust Custodian of the Register will send a short summary of the family and reasons for concern to all Chief Executive Officers of the eight Health Service Executives in the Republic of Ireland (see Appendix 3 for addresses).

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.

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- 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.

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- 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.

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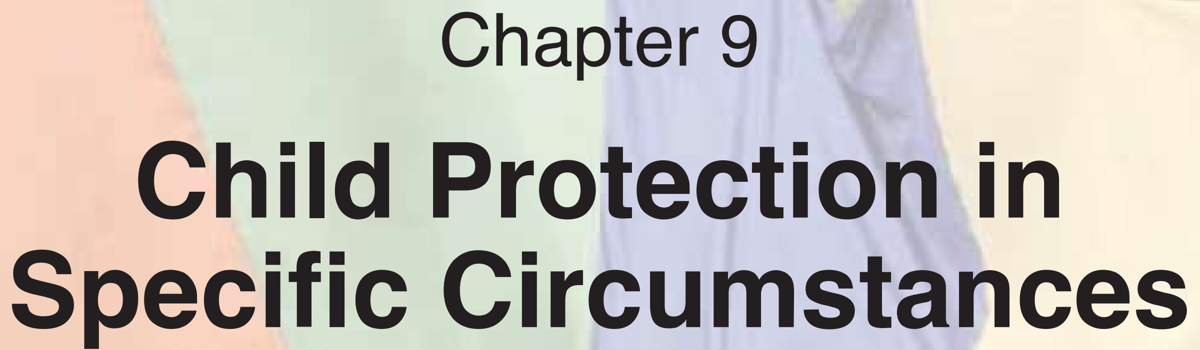


Chapter 9

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

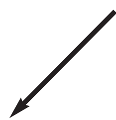
Referral to Child Care Team

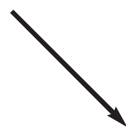
Child Care Team to notify & follow up in writing to the Disability Team (**Purpose: information sharing**)

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.

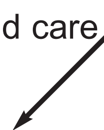
DECISION TAKEN





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.

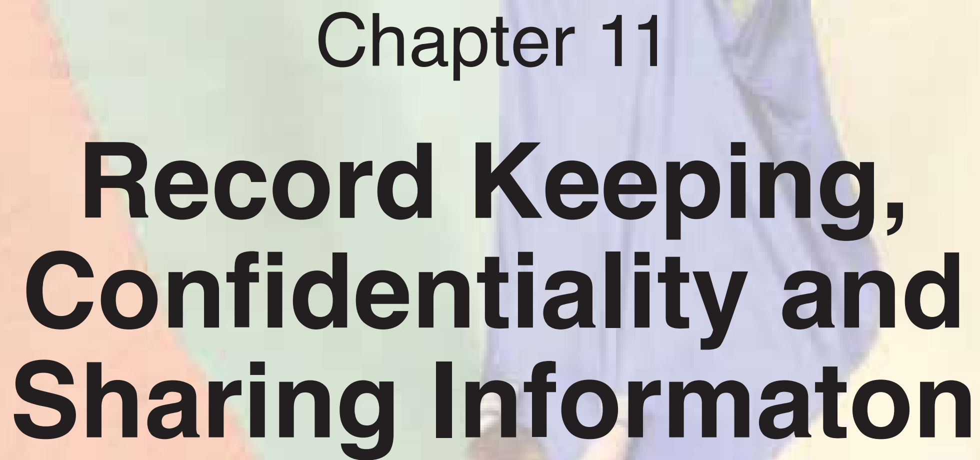
10.16 Staff from all agencies should be alert to current case law decisions on the sharing of information. Examples are cited in paragraph 7.4 of "Co-operating to Safeguard Children".

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.

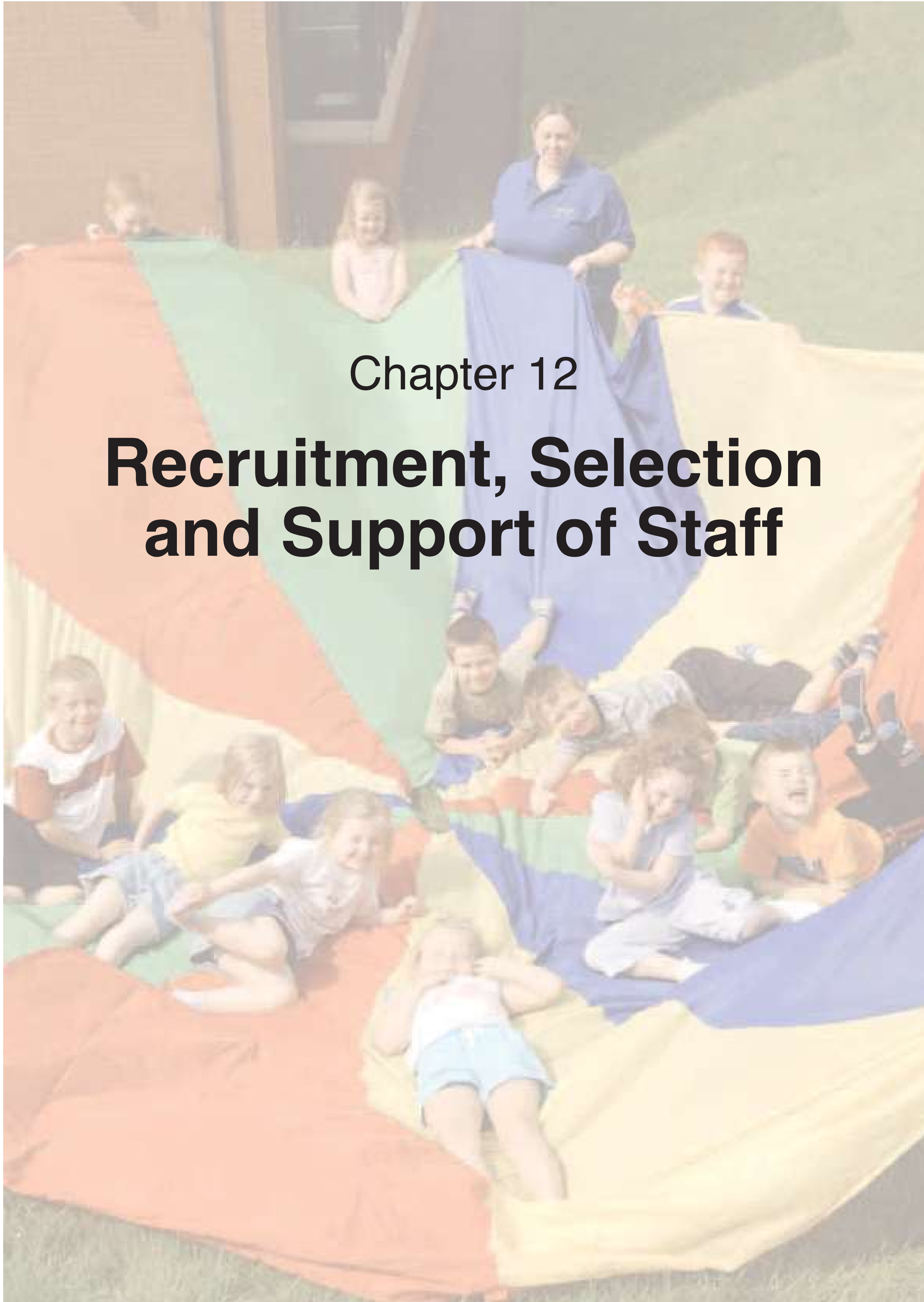
It is emphasised that these procedures **are not for the routine transmission of personal and confidential data**

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

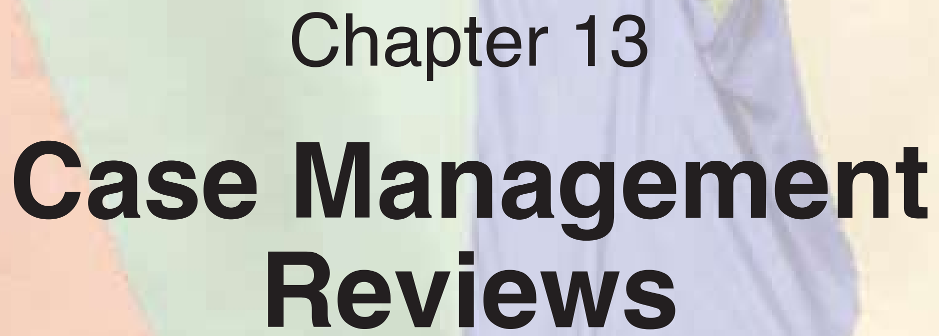
12.9 Child Protection work involves making difficult judgements. It is demanding work that can be stressful. All those involved must have access to supervision and support from managers on a frequent and regular basis in accordance with Agency policy and procedures. Social Work managers must provide 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:

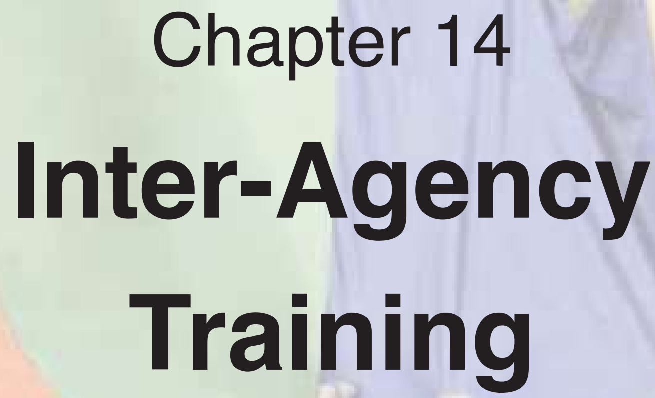
- establish the facts of the case
- establish whether there are lessons to be learned from the case about the way in which professionals and statutory and/or voluntary agencies work together to safeguard children
- identify clearly what those lessons are, how they will be acted upon, and what is expected 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

Relevant Publications & Bibliography

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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

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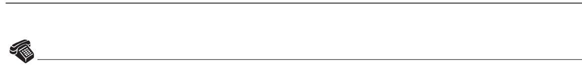

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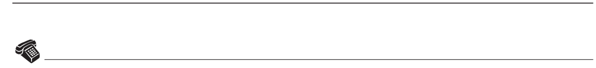

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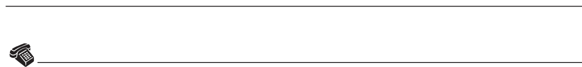

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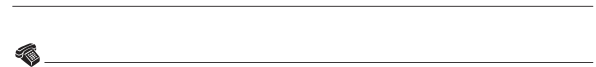

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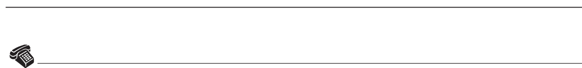

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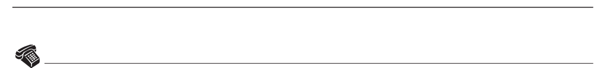

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NOTES

NOTES

Appendix 1

JULY 2005

NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

CHILD PROTECTION PROCEDURES

Rationale

This Muckamore Abbey Hospital Child Protection Procedure has been written in order to inform and guide all staff throughout the hospital about their special responsibilities for the protection of children from abuse and significant harm.

This procedure compliments and complies with the core policy and procedures set out in **"Co-operating to Safeguard Children" (May 2003)** and the **"Regional Child Protection Policy and Procedures" (May 2005).**

It should be noted that this hospital procedure deals only with aspects which will be important to staff in their everyday work with children with suspected and/or previously identified abuse and significant harm.

The hospital will ensure that the procedure will be implemented and the hospital will have representation on the Trust Child Protection Panel.

All children have the right to be protected from abuse and significant harm. Staff therefore have a duty to ensure that abuse or significant harm does not occur within any of the services for which they are responsible. There are children receiving assessment and treatment throughout the hospital. All staff will potentially be in contact with these children as part of their employment.

Child Protection in Hospital Settings

The Regional Child Protection Policy and Procedures makes particular reference to Child Protection in Hospital settings.

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 known about the child, from whatever source, when making decisions about the child's future care and management.
- 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 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 the arrangements are made for the child to be registered with a GP.

Children with Disabilities

The Regional Child Protection Policy and Procedures also makes specific reference to the needs of children with disabilities and their particular vulnerability to abuse.

Disability

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.

Abuse of Children with Disabilities

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

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.

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

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.

Staff involved with children's' 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.

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.

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.

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

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.

The Children Order defines a child as anyone under eighteen years of age and therefore includes young persons on adult wards.

Objectives

- to ensure that all staff who have concerns regarding child welfare will act in accordance with Co-operating to Safeguard Children and the Regional Child Protection Policy and Procedures.

- to ensure that all staff working with children will:

a. undergo training and awareness about their responsibility regarding the detection and management of abuse and significant harm.

b. be able to detect cases of suspected, alleged and actual abuse/significant harm through the recognition of signs and symptoms.

c. know and understand their statutory responsibilities with regard to the reporting to social services - both orally and in writing - of suspected or alleged cases of abuse of significant harm.

d. respond appropriately to known cases in a timely manner.

Response to all cases of suspected or alleged abuse or significant harm.

All staff should be responsive regardless of how the suspicion or allegation arises. Staff must remember that the child's welfare is paramount and they must report their concerns according to the procedures. Where appropriate a Strategy Meeting or Case Conference will be convened by the local Community Social Services Child Protection Team. Concerns about "triggering" child protection procedures which will include referral to the police and other agencies should never deter staff from reporting suspicions of child abuse.

Definitions - Abuse and Significant Harm

Abuse - Abuse falls into four categories - physical abuse, emotional abuse, sexual abuse and neglect.

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.

Physical 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

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

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.

Neglect

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).

Significant Harm

Harm is defined in the Children Order as "ill treatment or the impairment of health or development". This 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 behaviour development.

Whether 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.

Confidentiality

Where child abuse or significant harm is alleged or suspected, promises of secrecy must not be given and it should always be made clear to all parties involved that information will be shared in the interests of the child. The welfare of the child always remains paramount.

NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

CHILD PROTECTION PROCEDURES

Procedure for any member of staff who suspects that a child may be subject to abuse or significant harm.

Any member of staff may suspect abuse of significant harm from comments made by the child or carer, the physical condition of the child, the behaviour of the child or carer, the presenting medical condition or the behaviour of a colleague.

The following procedure directs staff in the reporting and investigation of suspected or alleged abuse or significant harm of a child. All staff are reminded of their responsibility in not further adding to the suffering of a child by omitting to take appropriate action at the earliest opportunity.

This procedure does not operate independently of other procedures such as complaints or disciplinary procedures but will always have precedence over these procedures given that the welfare of the child is paramount.

1. Any member of staff who has concerns must immediately protect the safety of the child whilst alerting others.

2. Once any member of staff has concerns he/she should report the case but should not proceed with any further direct interviewing of the child.

3. The staff member should discuss the case orally with their line manager. If concerns remain these should be documented and a referral should be made immediately to the hospital social work team who will refer the matter on immediately to Child Protection Team in the Trust area where the child usually lives. In the evenings, weekends or on public holidays the local Out of Hours Social Work Team should be contacted - numbers are shown in **Appendix 2** to this procedure for the out of hours arrangements for the particular Trust where the child usually resides. A written referral to the hospital social work team should follow on immediately and this will be forwarded immediately to the local Child Protection Social Workers.

   The referral will include the reasons for concern about the suspicion of child abuse or significant harm. This must include details of any observations made with regard to the child's physical, behavioural and emotional state and his/her interactions with parents/carers. Relevant information given by the child, parent/carer or any other person must be clearly noted and attributed. Particular reference should be made to any

explanatory statements about the aspects of the child's state which have given cause for concern.

4. All actions should be recorded in writing in the child's notes and copies of referral letters should be filed appropriately.

5. Where concerns are shown to be unfounded at any stage in the process a record should be made in the child's clinical and social work notes. Parents and all professionals previously contacted should be notified of this and parents should be made aware that no further child protection measures will be taken.

   Medical and nursing notes should contain medical/nursing information in respect of the child and should reference the social services investigation. The outcome of any case conference or investigation should be noted.

   Other professional reports should not be filed in the clinical/care plan notes but retained within the social services records.

   If parents wish to remove the child or obstruct investigation and this is deemed to put the child at risk of significant harm, legal advice may be sought by social services about the need to obtain an Emergency Protection Order. If time scales do not permit social services to be contacted, hospital staff should contact the police directly.

6. Discharge procedures - any child who has been investigated in relation to possible child abuse should not be discharged without appropriate consultation with the community services.

NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

CHILD PROTECTION PROCEDURES

Guidelines for Medical staff on the Management of Suspected Cases of Abuse or Significant Harm.

These guidelines are to be considered in context with the core policy and procedure set out in **"Co-operating to safeguard Children" (May 2003)** and the **"Regional Child Protection Policy and Procedures" (May 2005)**.

1. Any member of medical staff who has concerns must immediately protect the safety of the child who is in hospital, whilst alerting others.

2. Medical staff should not, either before or after reporting the case, proceed with further direct child or family investigations on their own.

3. (a) Where there are concerns about an injury and/or the physical or emotional welfare of the child medical staff should examine the child and if there are significant cause should:

   - discuss the concerns with the child's parents/carer.
   - ensure that the child's immediate medical needs are met.
   - report to the Consultant in charge who will in turn liaise with the Trust's designated medical officer.
   - hospital medical staff will continue to assist at the request of the designated medical officer.
   - document the investigation with appropriate photographic evidence.

   (b) Where there are concerns about sexual abuse the Consultant Psychiatrist will discuss with an appropriately trained and experienced colleague. Any subsequent investigation will follow the Joint Protocol for the Joint Investigation of Sexual Abuse.

Hospital medical staff should advise the strategy discussion on the mental welfare of the child and his/her capacity to give consent.

Child Protection Process

All medical notes to be retained/discarded in line with Regional Child Protection Policy and Procedures (May 2005).

Hospital medical staff should attend any case conference or strategy meeting to which they are invited. If unable to attend or send a representative a written report should be sent to the chairperson, ideally at least two working days prior to the meeting.

Hospital medical staff should advise on the nature of the abuse, its likely cause and compatibility or otherwise with any history given.

Record Keeping

Good contemporaneous notes should be kept:-

- Date and time of attendance.
- Who accompanied the child.
- What was the history of the presenting complaint. If patients or carers are quoted make sure this is clearly denoted.
- What was the child's physical, behavioural and emotional state and his/her interactions with adults and carers.
- Make drawings to identify sites and types of injury.
- Relevant information given by the patient or carers should be noted and particular attention should be given to the patient or carer's explanation about the aspects of the child's state which has given cause for concern.

NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

CHILD PROTECTION PROCEDURES

Guidelines for Nurses on the Management of Suspected Cases of Child Abuse and Significant Harm

Nurses have a major contribution to make where they suspect that a child has been, is being or is at risk of being abused or subjected to significant harm. It is essential that they discuss their concerns with the nurse in charge. The nurse must also immediately inform the Senior Nurse Manager on call and Consultant in charge of the ward.- who will agree who is best placed to inform the appropriate Social Services Team or Out of Hours Service.

- the nurse must record their cause/reason/suspicion of the child abuse in the patients care plan in black, dated and signed.
- it is important that only clear, concise, factual details are recorded on the child's physical, emotional and/or behavioural state.
- the nurse should also record the patients/guardians answers to questions, attitudes and reactions.
- record explanations from the child (if possible) and/or siblings and other adults about any significant change/deterioration.

Once the nurse has reported their concerns to the nurse in charge, staff must not undertake any further detailed investigations/examinations on their own behalf. They must await instructions from the Senior Nurse Manager.

The line manager will inform the Senior Social Worker or Duty Social Worker. However the nurse who suspects the abuse is accountable to communicate continuing concerns to Social Services and the Consultant.

If the concerns about the abuse are confirmed/founded a strategy meeting or case conference will be arranged by Social Services to determine a plan of action. Nursing staff will be invited to attend this and subsequent case conferences and may be asked to provide a report.

Written reports will normally be requested for case conferences. The nurse's report should be clear, concise, factual and legible (preferably typed). The nurse can discuss the report with his/her line manager or Child Protection Nurse prior to the case conference.
Junior Staff Nurses must always be supported by their line manager at case conferences. Nurses can seek advice about their roles and responsibilities in

child protection procedures from the Child Protection Nurse or Social Work Team.

If parents/guardians should attempt to remove the child from the ward/hospital and there is reason to believe that the child is at risk the nurse in charge should immediately contact the Senior Social Worker or the Duty Social Worker on call as legal procedures may need to be invoked.

Nurses must adhere to the NMC's guidelines about documentation. The nurse is responsible for documenting in the child's care plan:-

1. date and time
2. concerns/suspicions
3. whom they have consulted - giving full name, dates and time
4. planned actions/outcomes
5. sign and date same

The nurse's notes must be clear, concise and factual as these can be used in legal proceedings.

NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

CHILD PROTECTION

Procedures for known cases of child abuse or children already known to be on the Child Protection Register

There may be situations when children already known to be on the Child Protection Registrar are either being transferred from another hospital or admitted from the community.

Careful attention is required at admission to ensure that detailed written admission procedures, as under noted, are adhered to.

- Professionals from the referring hospital or social services should be asked by the Consultant Psychiatrist to ensure that all relevant information is forwarded in writing and that this information is transferred with the child. This task is usually designated to the ward social worker.
- Written information should include a record of the category of abuse or significant harm, identify the social work team carrying the case and identify who has legal responsibility if consent for medical procedures is required.
- Any limits which carers have to access must be clearly recorded in nursing and medical notes.
- Particularly in the case of suspected abuse, the child and carer should be asked during interview about other previous contacts/admissions to any other hospital and any fresh concerns should be referred to Social Services.

Appendix 2

Training details on Child Protection, Vulnerable Adult and Management of Aggression within Muckamore Abbey Hospital

It is anticipated that all these will be mandatory i.e. within first six months of employment.

Child Protection

Since April 2005, Child Protection Training has been delivered locally at Muckamore and staff have attended Training at the Millennium Outreach Centre(provided by the Social; Services Training unit).
Two members of the Senior Nursing Team have been trained to deliver the training locally in partnership with the North & West Belfast Social Services Training Unit.

The training consists of:

1 day – Level 1 for:

All qualified nursing staff
Senior Day Care Workers
Heads of Departments
Medical Staff
Senior Management

To date 78 staff have attended this course within the hospital.

In addition 16 staff from Conicar, Movilla B and Fintona South have attended this course at the Millennium Centre.

It is anticipated that the majority of the relevant staff will have had this training by the end of March 2006. After this the training will be provided at the Millennium Centre.
.

The trainers from Muckamore Abbey will only be called upon if required.
The Inservice coordinator at Muckamore Abbey will be kept advised of any developments or issues regarding training.

Awareness Training

Two hour awareness sessions will commence in February 2006 for:

- All unqualified Nursing Staff
- Daycare staff
- Support Service Staff

This will be delivered at Muckamore Abbey and will be ongoing until all staff have been trained – estimated time, one year.

Newly appointed staff to Muckamore Abbey will receive this training as soon as possible, (qualified staff at Millennium Centre. Unqualified staff will receive as part of local induction programme at Muckamore.

Vulnerable Adult Training

For nursing and day care staff, vulnerable adult training is accessed through the Beeches In-service Consortium. This is a two hour session held on a monthly basis.

All nursing and day care staff are expected to attend this to date 107 nursing staff and 50 day care staff have attended.

In addition to this120 staff from various disciplines at Muckamore Abbey have attended Vulnerable Adult training with the Social Services Training Unit, since 1998. This includes awareness and Specialist/Designated Officers training 6 Senior Nurse Managers are due to have Designated Officer refresher training early in 2006.

It is estimated that all Nursing Staff will have appropriate Vulnerable Adult Training by December 2006.

Vulnerable Adult Training will also be a first for newly appointed staff within six months of taking up post.

Management of Aggression Training

Management of Aggression Training at Muckamore Abbey is delivered by Hospital based Trainers who have received specialist training.

The training is provided by an organisation called Positive Options – based in England.

This organisation has been accredited by BILD (British Institute of Learning Disabilities). Currently there are six trainers with full accreditation, with an additional one being processed.

The training consists of:

Five day course

Which is 50% theory, 50% practical. It is expected that all nursing staff/daycare should avail of this although priority has been given to the wards with the highest risk of challenging behaviour.

Two day refresher

Each member of staff who attends a five day course must attend a refresher within 18 months (failure to do so results in the person having to repeat the five day course).

One day breakaway

This is designed to staff who may come into contact with patients who display challenging behaviour and may need to react quickly to keep themselves safe and to be aware of the triggers of aggression.

Two day course for bank staff

This course has been designed to manage the awareness of bank staff who do not work permanently in the hospital but by the nature of their employment may frequently be faced with challenging behaviour.

Since 1997, staff who have had full training.

Senior Nurse Manager/Asst Director	6	100%
Night Supervisory Staff	5	100%
Ward Based Nursing Staff	321	

Since training began these are the staff who have had a five day training course.

With staff turn over approximately 40 new staff per year require training. This pattern is likely to continue for the next few years. It is anticipated that the current staff should have received a five day course within the next 18 months – with priority given to the high-risk area.

Day Care – All staff have received the training.

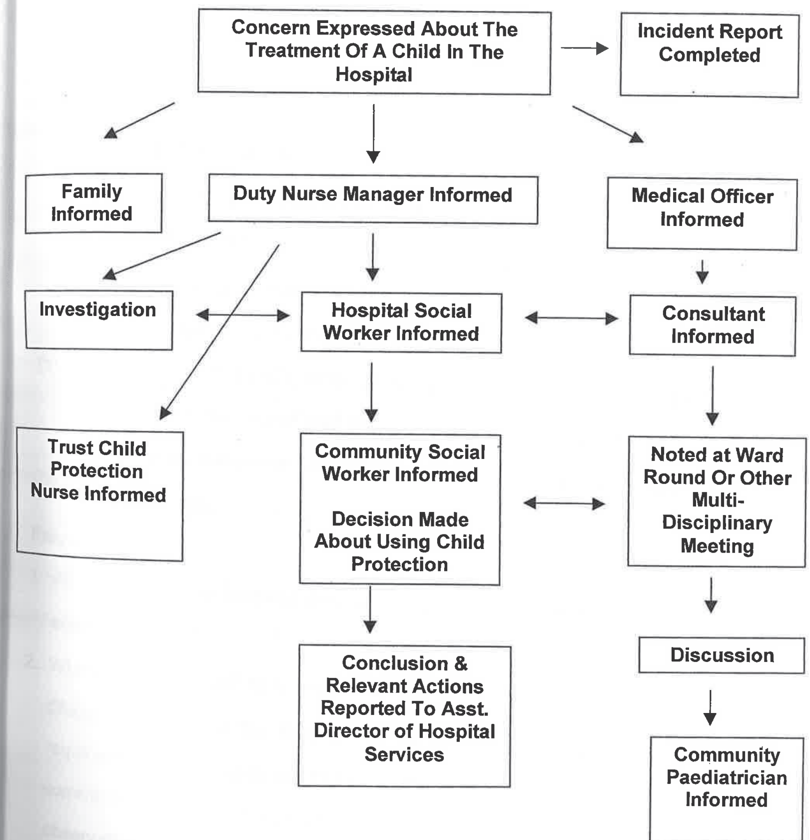
Bank Staff – 63 have either attended full course (i.e. permanent employees or attended the back staff course.

Frequency of training

Five day course – minimum 9 per year
Two day refresher – minimum 15 per year
Bank staff – as required usually 2 per year
Breakaway – as require usually 2 per year

Appendix 3

CHILD PROTECTION REPORTING FLOWCHART



Contact Details
Child Protection Nurse, Ms Helen Tomb, Tel No. 02890 320840
Consultant Paediatrician, Dr Joanne Nelson, Tel No. 02890 327613

Safeguarding Adults

A National Framework of Standards for good practice and outcomes in adult protection work

Leaders in social care

'Safeguarding Adults'

A National Framework of Standards
for good practice and outcomes in adult protection work

This framework has been developed through the ADSS-led national 'Safeguarding Adults' network, which combines partner representation alongside adult protection representatives from ADSS branches. It has received a wide range of support and contributions from stakeholders.

The framework has been developed from existing practice, with contributions by adult protection lead managers throughout the country, and shaped in consultation and partnership with:

Association of Chief Police Officers (ACPO)
Commission for Social Care Inspection (CSCI)
Department of Health (DoH)
Public Guardianship Office (PGO)
Practitioner Alliance against Abuse of Vulnerable Adults (PAVA)
Ann Craft Trust (ACT)
VOICE UK

'Safeguarding Adults' Network editorial sub-group: Sue Fiennes, Chair (Herefordshire), Ruth Ingram, Editor (Bradford), Leo Quigley (Sheffield), Joanne Pell (Sunderland) and Jane Robinson (Bolton).

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Introduction

I am very pleased to introduce this document. It is the result of the combined expertise of those who have been leading the development of adult protection work in England since the publication of 'No Secrets' by the Department of Health and the Home Office (March 2000). 'No Secrets' was published for use by all health and social care organisations and the police, in a multi-agency context led by local authorities with social services responsibilities.

Since the publication of 'No Secrets', at least 90 local authorities have appointed a lead officer for 'adult protection work'. In some areas they built on systems already in place before March 2000. In most areas the work has been directed by a multi-agency partnership. Through this work, much has been learnt about best practice. Most importantly, more adults "with community care needs" have been enabled to live safer lives, both in their own homes and communities, and also within services such as hospitals, care homes and day resources.

In our role as Directors of Social Services, holding responsibility for leading the development of this work, the Association of Directors of Social Services (ADSS) has now published this National Framework document. Our aim is to consolidate our experience to date and to further the development of 'Safeguarding Adults' work throughout England.

This document collects best practice and aspirations together into a set of good practice standards – which is intended to be used as an audit tool and guide by all those implementing adult protection work We have included some examples of good practice from around the country and further examples are detailed in recent publications by the Practitioner Alliance against abuse of Vulnerable Adults (PAVA).

Whilst this framework is written from our perspective of leading the work from within local government, it is prepared with full acknowledgement that this is a multi-agency task. There are many items in this toolkit that relate to all agencies, as well as to our working together in partnership. In this context, I particularly welcome the support and contributions from partner organisations.

Much good work has been done to safeguard adults, but much more still remains. There are significant numbers of adults for whom abuse and disability compromise their access to safety, to the civil and criminal justice system; to victim support services; to housing; to health and social care and to protective networks of family, friends and community.

The responses we received during the consultation indicate strong support for the creation of a consistent national framework for 'Safeguarding Adults' work. We hope that this document will assist in that process.

Sue Fiennes

Sue Fiennes
ADSS Lead/Chair
'Safeguarding Adults' Network

October 2005

Executive summary

This national framework is comprised of eleven sets of good practice standards. We believe their implementation in every local area will lead to the development of consistent, high quality adult protection work across the country.

HEADLINE STANDARD	
Standard 1	Each local authority has established a multi-agency partnership to lead 'Safeguarding Adults' work.
Standard 2	Accountability for and ownership of 'Safeguarding Adults' work is recognised by each partner organisation's executive body.
Standard 3	The 'Safeguarding Adults' policy includes a clear statement of every person's right to live a life free from abuse and neglect, and this message is actively promoted to the public by the Local Strategic Partnership, the 'Safeguarding Adults' partnership, and its member organisations.
Standard 4	Each partner agency has a clear, well-publicised policy of Zero-Tolerance of abuse within the organisation.
Standard 5	The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group. The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.
Standard 6	All citizens can access information about how to gain safety from abuse and violence, including information about the local 'Safeguarding Adults' procedures.
Standard 7	There is a local multi-agency 'Safeguarding Adults' policy and procedure describing the framework for responding to all adults *"who is or may be eligible for community care services"* **and** who may be at risk of abuse or neglect.
Standard 8	Each partner agency has a set of internal guidelines, consistent with the local multi-agency 'Safeguarding Adults' policy and procedures, which set out the responsibilities of all workers to operate within it.
Standard 9	The multi-agency 'Safeguarding Adults' procedures detail the following stages: Alert, Referral, Decision, Safeguarding assessment strategy, Safeguarding assessment, Safeguarding plan, Review, Recording and Monitoring.
Standard 10	The safeguarding procedures are accessible to **all** adults covered by the policy.
Standard 11	The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service-user participation into its: membership; monitoring, development and implementation of its work; training strategy; and planning and implementation of their individual safeguarding assessment and plans.

Context and definitions

A duty to safeguard adults

All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: 'the Right to life'; Article 3: 'Freedom from torture' (including humiliating and degrading treatment); and Article 8: 'Right to family life' (one that sustains the individual).

Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse.

It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services. Remedies available should also include measures that achieve behaviour change by those who have perpetrated abuse or neglect.

"Abuse is a violation of an individual's human and civil rights by any other person or persons." *'No Secrets' (DH 2000)*

The need for 'Safeguarding Adults' work

The experience of abuse and neglect is likely to have a significant impact on a person's health and well being. By its very nature abuse – the misuse of power by one person over another – has a large impact on a person's independence. Neglect can prevent a person who is dependent on others for their basic needs exercising choice and control over the fundamental aspects of their life and can cause humiliation and loss of dignity.

Adults who *"may be eligible for community care services"* are those whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include carers: family and friends who provide personal assistance and care to adults on an unpaid basis. They are not a self-defined community, but a group that has been created by social policy. This document is based on the premise that when an adult in this group is experiencing abuse or neglect this will have a significant impact on their independence, health and wellbeing.

If **all** adults were able to effectively access support to live safer lives at the time they needed it, there would be no need for policies and procedures aimed at addressing the needs of specific groups of people. However, the publication of 'No Secrets' was based on the premise that some groups of adults experience a higher prevalence of abuse and neglect than the general population and that they are also not easily able to access services to enable them to live safer lives. The work that has taken place since the publication of 'No Secrets' has confirmed that this is the case.

The groups of adults targeted by 'No Secrets' were those *"who is or may be eligible for community care services"*. And within that group, those who *"were unable to protect themselves from significant harm"* were referred to as *"vulnerable adults"*. Whilst the phrase "vulnerable adults" names the high prevalence of abuse experienced by the group, there is a recognition that this definition is contentious. One reason is that the label can be misunderstood, because it seems to locate the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others.

Another reason is that the definition has become confused because there are multiple definitions of a *"vulnerable adult"* in use within current government policy, for example: No Secrets (DH 2000); Care Standards Act 2000 (Establishments and Agencies - Miscellaneous Amendments- Regulations 2004), relating to the Protection of Vulnerable Adults Index; and the 1999 Youth Justice and Criminal Evidence Act: Part II, relating to 'Achieving Best Evidence'.

In addition, since 'No Secrets' was published, there have been some significant legal and policy changes relating to adult social and health care, together with a re-focusing of its language and philosophy. In particular, 'Fair Access to Care' (DH 2002) stresses 'risk to independence and well being ' as the key criteria for determining eligibility for care services, and therefore replaces the concept of a *"vulnerable adult"* with an assessment of the risk posed by the abuse and neglect to the quality of life of the individual adult concerned.

Furthermore, the emphasis is now on supporting adults to access services of their own choosing, rather than 'stepping in' to provide protection. 'Better Government for Older People' is an example of how the promotion of active citizenship for all is becoming viewed as holding a central role in preventing risks to independence. In the meantime, the duty to provide protection to those who do not have the mental capacity to access it themselves has become clearer (e.g. Human Rights Act 1988, Mental Capacity Act 2005, Domestic Violence Crime and Victims Act 2004).

In recognition of the changing context, previous references to the protection of *"vulnerable adults"* and to *"adult protection"* work are now replaced by the new term: **'Safeguarding Adults'.** This phrase means all work which enables an adult *"who is or may be eligible for community care services"* to retain independence, wellbeing and choice **and** to access their human right to live a life that is free from abuse and neglect. This definition specifically includes those people who are assessed as being able to purchase all or part of their community care services, as well as those who are eligible for community care services but whose need - in relation to safeguarding - is for access to mainstream services such as the police.

'Safeguarding Adults' procedures refer to the local area-based, multi-agency response which is made to every adult *"who is or may be eligible for community care services"* (National Health Service & Community Care Act 1990) **and** whose independence and wellbeing is at risk due to abuse or neglect.

Whilst these particular adults are the specific focus of 'Safeguarding Adults' policy and procedures, this does not negate the public duty of those carrying out this work to protect the human rights of **all** citizens, including those who are the subject of concern but are not covered by these procedures, or those who are not the subject of the initial concern.

Such work is the responsibility of all agencies and cannot exist in isolation. It must be effectively linked to other initiatives, as part of a network of measures aimed at enabling all citizens to live lives that are free from violence, harassment, humiliation and degradation.

Joint planning and capability

Standards 1 and 2

Standard 1 The Partnership

This Standard sets out the framework within which the planning, implementation and monitoring of 'Safeguarding Adults' work should take place. The key structure in this framework is a multi-agency partnership that leads the development of the work at a local level: the **'Safeguarding Adults' partnership.**

The impetus for a multi-agency approach is the recognition that a plethora of organisations is involved in providing services to adults and may be involved in enabling them to access safety. In addition there are published inquiries into situations where abuse of adults has taken place and not been recognised or acted on in time to prevent harm. These include those examining the circumstances of deaths of adults in their own homes and the abuse and neglect of people living in care settings, (for example: Beverley Lewis, (Lamb L 2000) Independent Long Care Inquiry (Bergner T 1998), North Lakeland Healthcare NHS Trust (CHI November 2000) and Rowan ward, Manchester Mental Health and Social Care Trust (CHI September 2003). Each inquiry contains the theme that greater information-sharing and multi-agency working together may have placed organisations in a position to safeguard the adults concerned.

Strong partnerships are those whose work is based on an agreed policy and strategy, with common definitions and a good understanding of each other's roles and responsibilities. These underpin partnership working in response to instances of abuse and neglect, wherever they occur.

Local Crime and Disorder Partnerships have the lead role for delivering the Safer Communities agenda. The 'Safeguarding Adults' strategy should be included within the Crime and Disorder Reduction Strategy and be endorsed by the Local Strategic Partnership. It is also important that 'Safeguarding Adults' work is closely linked to other partnership initiatives -particularly those aimed at enabling all adults to have access to healthy, active and fulfilling lives - and is included within the Local Delivery Plan for health services.

Standards

1.1 Each Local Authority has established a multi-agency partnership to lead 'Safeguarding Adults' work.

1.2 The partnership includes representation from all the appropriate statutory agencies *(see good practice table below).*

1.3 Accountability for leading the creation and maintenance of this partnership is clearly located with the Local Authority, designated to the Director for Adult Social Services and overseen by an appropriate scrutiny board.

1.4 The 'Safeguarding Adults' Partnership is endorsed by and clearly linked to the Local Strategic Partnership via the Crime and Disorder Reduction Partnership.

1.5 The 'Safeguarding Adults' strategy is referenced in the Local Delivery Plan.

GOOD PRACTICE
'Safeguarding' Adults' – Partnership Membership and links
(as appropriate for the local area)

Statutory organisations	Other potential members	Links to other partnerships
Local Authority ■ Adult Social Services ■ Housing ■ Welfare Rights/Benefits ■ Education/Community Education ■ Legal Services ■ Licensing Police Crown Prosecution Service Probation Primary Care Trusts Other NHS Care Trusts Hospital Trusts Commission for Social Care Inspection Health Care Commission Strategic Health Authority Housing Trusts Supporting People Board Department of Work and Pensions **Definitive links to** Coroner Public Guardianship Office Courts Witness Service Fire Service Ambulance Service	Service users'/patients' organisations Carers' organisations Advocacy providers Direct Payments 'Umbrella' organisation Care Home and Domicilary Care providers/associations Supporting People providers Victim support services e.g. Victim Support, Rape Crisis, Women's Aid Voluntary sector service providers e.g. Age Concern, Help the Aged, MIND, People First, MENCAP, SCOPE Voluntary sector groups working against abuse of adults e.g. ACT, Action on Elder Abuse, PAVA, POPAN.	Local Strategic Partnership ■ Regeneration ■ Health ■ Crime and Disorder Reduction Board ■ Domestic Violence ■ Drug and Alcohol ■ Neighbourhood forums/ Communities of interest MAPPA (Multi-Agency Public Protection Arrangements) Strategic Safeguarding Boards (Children) Joint planning and commissioning for people with: Learning Disabilities Mental Health issues Long term and chronic illnesses and Disabled people Older people Carers

1.6 The 'Safeguarding Adults' Partnership also has strong links to Regeneration work and the promotion of health and citizenship. Plans and targets for 'Safeguarding Adults' are owned by these wider partnerships.

1.7 Plans and targets for 'Safeguarding Adults' are included within any specific partnerships working with people covered by the policy, for example: service frameworks for older people, people with a learning disability, people with mental health problems, carers, disabled people and people with chronic or terminal illnesses.

1.8 The partnership has identified and agreed which local partnerships it should have representation on and to.

Joint planning and capability

GOOD PRACTICE
Role of 'Safeguarding Adults' Co-ordinator

Many Local Authorities have appointed an 'Adult Protection ('Safeguarding Adults') Co-ordinator' to support the work of the partnership. This role should be clearly defined, and including responsibility to:

1) Advise and support the partnership
2) Advise and support partnership members in the implementation of 'Safeguarding Adults' work within their organisation
3) Maintain an overview of the development of local 'Safeguarding Adults' work
4) Provide information about relevant national and regional developments
5) Collate monitoring and quality assurance information
6) Provide information and advice on the implementation of the 'Safeguarding Adults' procedures to all
7) Provide information and advice to the **Safeguarding Managers** *(see Standard 9)*

It may also include responsibility to:

8) Plan and commission work to be undertaken by the partnership
9) Manage work undertaken by the partnership. This often includes the partnerships joint training and information strategies. In some areas it includes the management of a 'Safeguarding Adults' Unit which includes dedicated **Safeguarding Managers.**

1.9 The 'Safeguarding Adults' partnership has:

- A Chair with established authority
- Membership from all statutory organisations listed below
- Membership from voluntary and independent sector service providers
- Representation from service users' and carers' organisations
- Representatives to and from relevant strategic partnerships
- An executive management to oversee strategic development of the work
- Terms of reference
- A strategic/forward plan

1.10 Members of the Safeguarding Partnership are sufficiently senior in their organisations to represent that organisation and to make multi-agency agreements.

1.11 The partnership ensures that sufficient resources are available to meet its strategic/forward plan.

1.12 The strategic plan includes:

- 'Safeguarding Adults' policy – development and review
- 'Safeguarding Adults' procedures for reporting and responding to concerns of abuse or neglect– monitoring, development and review
- Equal access strategy
- Information-sharing agreement – development and review
- Training strategy for all staff and volunteers
- Training strategy for service users and carers
- Strategy to disseminate information about adult abuse and 'Safeguarding Adults' work to staff, volunteers, service users, carers and members of the public
- A commissioning strategy for services for people who are at risk of/have experienced abuse or neglect
- A commissioning strategy for responses to and services for perpetrators of abuse/neglect
- Strategies for reducing risk of abuse and neglect across a range of settings, including care settings and the community
- Review of the strategic plan and publication of an annual report.

1.13 The definition of abuse used in the policy and procedures is consistent with that in 'No Secrets' (DH 2000) *(see page 5)*

1.14 The policy and procedures cover every adult *"who is or may be eligible for community care services"* facing a risk to their independence due to abuse or neglect.

1.15 The process of writing and reviewing the strategic plan is a joint effort between agencies. The plan is formulated after consultation with adults covered by the 'Safeguarding Adults' policy and procedure, as well as with frontline staff and volunteers.

1.16 The strategic plan is signed up to by all partner agencies at senior executive/board level.

1.17 There is an agreement about each agency's respective roles and how these dovetail together to effectively implement the strategic plan.

1.18 There are effective arrangements for the monitoring of 'Safeguarding Adults' work by partner agencies and for the collation of data on behalf of the partnership.

1.19 There are quality assurance arrangements for the service provided to those referred to the 'Safeguarding Adults' procedures and for the development of those procedures on the basis of lessons learnt.

1.20 Information collected for monitoring purposes conforms to national guidance (e.g. 'No Secrets') and requirements for 'Safeguarding Adults' Partnerships and individual partner organisations.(See also work in progress on national reporting standards DH/AEA.)

1.21 Quality assurance processes and outcome information is used to develop forward plans e.g. for service development, information/publicity work, training.

Joint planning and capability

1.22 There is 'Safeguarding Adults' serious case review protocol. This is agreed, on a multi-agency basis and endorsed by the Coroner's Office, and details the circumstances in which a serious case review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a domestic violence homicide review should be clear.

1.23 There is an agreed multi-agency protocol for the commissioning and undertaking of a 'Safeguarding Adults' serious case review.

1.24 There is an annual review by the partnership of the progress of work within each partner organisation, within an agreed framework which meets Standard 2 below.

1.25 There is an annual review by the partnership of progress on its strategic plan using this national framework, and an annual report is produced.

1.26 The annual review includes consultation with adults covered by the 'Safeguarding Adults' policy and procedures.

Standard 2 Partner organisations

Working together is dependent on there being a clear framework for doing so. However, a successful partnership is built on the strength and capacity of individual organisations and is dependent on each partner being committed to engaging in the work.

'Safeguarding Adults' work is based on communication across agency boundaries. It is important that each partner has a good understanding of its role in the work of 'Safeguarding Adults' and making a clear commitment of resources appropriate to that role. Fundamental to this commitment is the implementation of good practice in the prevention of abuse and neglect within the service provided by the organisation *(see Standard 4).*

Each organisation is responsible and accountable for meeting national guidance and legal requirements in relation to implementing 'Safeguarding Adults' work, whether through working in partnership or through its own actions.

Each organisation has a responsibility for working actively in partnership in order to implement 'Safeguarding Adults' work.

Standards

2.1 Accountability for and ownership of 'Safeguarding Adults' work is recognised by each partner organisation's executive body.

2.2 Each organisation has designated a lead director for the implementation of this work and a senior representative on the 'Safeguarding Adults' Partnership.

2.3 The representative has clear lines of accountability and feedback for this aspect of their work within their organisation.

2.4 The lead director provides yearly reports to the executive body of the organisation.

2.5 Each partner organisation provides an annual statement to the 'Safeguarding Adults' partnership for its endorsement describing:

- the organisation's role in the work
- any specific professional responsibilities and legal obligations that their organisation will adopt within 'Safeguarding Adults' policies and procedures
- the internal reporting and decision-making framework in relation to any concerns that an adult may be experiencing abuse or neglect *(see Standard 8)*
  and its achievements and organisational plans for:
- the internal implementation of 'Safeguarding Adults' work
- disseminating information about the principles of the work within the organisation
- ensuring all staff and volunteers have the understanding and skills to carry out their roles and duties in relation this work
- ensuring all service users and carers are aware of the 'Safeguarding Adults' policy and procedures
- providing monitoring information to the partnership

Joint planning and capability

2.6 Each organisation audits its policies and procedures – using a format agreed by the partnership - for effectiveness and for consistency with the multi-agency 'Safeguarding Adults' policies and procedures, and makes any necessary changes.

2.7 Each organisation cross-references its 'Safeguarding Adults' plans with its core business plans and includes standards and targets relating to 'Safeguarding Adults' in them.

2.8 Each organisation includes appropriate actions relating to 'Safeguarding Adults' within its mainstream activities.

GOOD PRACTICE EXAMPLE (SHEFFIELD)

Audit of partner organisations' capacity for 'Safeguarding Adults'

	Does your organisation have:	Yes	No
1	A lead person at Board level with responsibility for 'Safeguarding Adults'		
2	Does the Board receive an annual report on this work		
3	A lead officer/manager		
4	A reference group		
5	An appropriate representative on the local area 'Safeguarding Adults' Partnership who has a clear line of responsibility back into the organisation		
6	A financial commitment to multi-agency 'Safeguarding Adults' work		
7	A clear reporting structure by which staff can raise concerns of abuse or neglect		
8	Ability to supply 24-hour access to 'Safeguarding Adults' information		
9	Ability to supply 24-hour access to all previous case records		
10	24-hour access to other agencies' information		
11	24-hour access to a person with 'Safeguarding Adults' expertise		
12	A person with the lead for ensuring CRB, POVA and other relevant checks of staff are made		
13	A person with the lead for ensuring professional staff are registered with their professional body		
14	Clear service specifications and standards for 'Safeguarding Adults' work		
15	A training strategy for all staff and volunteers		
16	A monitoring system for this work		

Prevention of abuse and neglect

Standards 3, 4 and 5

A comprehensive and systematic study has not yet been carried out in England into the prevalence and impact of the abuse and neglect of adults covered by 'Safeguarding Adults' policies. However, information from small scale studies (e.g. MENCAP 1999, DH/Action on Elder Abuse 2005) indicates that the prevalence of such abuse is higher than in the rest of the adult population.

Aspects of peoples' lives that can explain this increased vulnerability to abuse include:

- Lack of inclusion in protective social networks, including education and employment
- Dependency on others (who may misuse their position) for vital needs including mobility, access to information and control of finances
- Lack of access to remedies for abuse and neglect
- Social acceptability of low standards for care and treatment
- Social acceptability of domestic abuse
- Dynamics of power within institutional care settings

It follows that a key aspect of the prevention of abuse and neglect is that local forums and planning processes (e.g. those dealing with crime and disorder, regeneration and health and wellbeing) are accessible to, influenced by and monitor inclusion of, people covered by the 'Safeguarding Adults' policy.

Local audits of education, leisure and commercial activity must include monitoring of involvement by people covered by the 'Safeguarding Adults' policy.

In particular, those services that respond to issues of crime prevention and to incidents of violence and abuse must be accessible to people covered by the 'Safeguarding Adults' policy.

Prevention of abuse and neglect

Standard 3 In the community

Standards

3.1 The 'Safeguarding Adults' policy includes a clear statement of every person's right to live a life free from abuse and neglect.

3.2 This message is actively promoted to the public by the Local Strategic Partnership, the 'Safeguarding Adults' partnership, and its member organisations.

3.3 'Safeguarding Adults' is a key theme within the local Crime and Disorder Reduction Boards strategy. All relevant sub-strategies should be audited to ensure they are effective for, and that relevant services are accessible to, those citizens who are covered by the 'Safeguarding Adults' policy.

3.4 There is a locally endorsed charter for victims, which is cross referenced to and by the 'Safeguarding Adults' policy and procedures.

3.5 Each organisation that responds to issues of crime prevention and to incidents of violence and abuse, monitors provision of services to people covered by the 'Safeguarding Adults' policy and provides reports to the partnership.

3.6 Activities aimed at enhancing the personal safety of individuals (e.g. assertiveness courses, self-defence training, personal safety advice, provision of personal safety equipment) audit attendance and act to increase their accessibility to people covered by the policy.

3.7 Frontline organisations that provide housing, education, leisure, health and social care services make information about crime prevention available and accessible to service users and, where appropriate, support them to access mainstream services to access safety.

3.8 Commissioners, regulators and licensing bodies of mainstream services (e.g. leisure centres, colleges, public transport, taxis and trading standards) should ensure that employers implement appropriate safeguards and responses to Safeguarding Adults issues.

3.9 Commissioners of community care services collect data about assessed needs for crime prevention measures and victim support services and work with local partnerships to meet identified needs.

3.10 People who are known to pose a risk to others within the community, including those covered by the Safeguarding Policy, are the subject of a plan drawn up under the Multi-Agency Protection Panel Arrangements (MAPPA).

Standard 4 Within service delivery

Adults who are receiving community care services can be at risk whilst receiving them, both in care settings and in their own homes. Successful prevention of adult abuse and neglect demands that service providers tackle the factors which contribute to its occurrence at all levels. Commissioners and regulators of community care services play a vital role in ensuring that people receive care services from organisations which implement standards that prevent abuse and neglect.

Organisations which are regulated by CSCI, the Health Commission, and commissioned through PCTs and SSDs must be expected to fulfil these standards. In addition, 'Safeguarding Adults' Partnerships can form agreements with other local providers of community care services which require them to implement the same standards.

The standards below should also be considered by national partner organisations e.g. large voluntary organisations, professional bodies and by local organisations providing other types of services, such as civil and criminal justice and advocacy.

Relevant measures include:

- Zero-Tolerance of abuse and neglect within the organisation
- Crime prevention and safety audits
- Upholding the human rights of all service users and carers
- Promotion and delivery of choice of services to all service users
- Quality care planning and delivery for each service user
- Recruitment and selection screening of staff and volunteers for those who may cause abuse
- Training and supervision of staff and volunteers to promote quality standards of service delivery
- Effective feedback mechanisms from staff, volunteers and service users
- Effective quality assurance and governance processes.

Standards

4.1 Each partner agency has a clear, well-publicised policy of Zero-Tolerance of abuse within the organisation.

4.2 This policy is underpinned by clear procedures that cover all incidents of abuse from any person towards any other e.g. staff-staff, service user-staff, as well as those covered by the 'Safeguarding Adults' policy e.g. staff-service user, service user-service user.

4.3 Each partner agency's 'Safeguarding Adults' procedure is consistent with the multi-agency procedure, and all incidents of abuse covered by that procedure are referred to it without delay.

4.4 Each partner agency implements the 'Safeguarding Adults' information-sharing protocol.

Prevention of abuse and neglect

GOOD PRACTICE EXAMPLE (ANCHOR TRUST)
Policy Statement for Rights and Responsibilities

Anchor believes that people have a right to live and work in an environment free of the threat of abuse, harassment, violence or aggression. As an employer committed to the provision of a safe workplace, Anchor will work to protect employees from harassment, violence or aggression from colleagues or customers. Anchor will equally seek to protect customers from violence, aggression or abuse from friends, relatives, employees or other customers.

4.5 Each partner organisation publicises its 'Safeguarding Adults' policy and procedures to all staff, volunteers, service users and carers in ways which are appropriate and accessible.

4.6 There is a clear policy and procedure for reporting all suspected crimes taking place within the service to the police.

4.7 Each partner organisation carries out a crime prevention and safety audit on an annual basis which includes an audit of abuse of service users.

4.8 Each partner organisation has clear policies against discrimination and harassment towards any person (staff, volunteers, service users, carers) on any grounds including disability, age, race, faith, gender or sexuality.

4.9 Each partner organisation has clear, accessible and well-publicised complaints procedures. This includes information about how to complain to external bodies such as regulators and service commissioners, and is cross-referenced with the 'Safeguarding Adults' procedures. Relevant advocacy and advisory services are well-publicised.

4.10 Each partner organisation has effective quality assurance and governance processes that are cross-referenced with 'Safeguarding Adults' issues.

4.11 There is a procedure in each organisation by which staff and volunteers can raise concerns and protection for 'whistleblowers' in accordance with guidance produced by 'Public Concern at Work'. This is cross-referenced with the 'Safeguarding Adults' procedures.

4.12 There is an 'open culture' within partner agencies. This includes good communication between staff and managers and with all stakeholders, for example: regular feedback activities during which staff, volunteers, other professionals, service users and carers can report on how the organisation is working in practice.

4.13 If appropriate, each partner organisation has clear operational guidelines, in accordance with regulations and best practice guidance, in relation to:

- Serious incidents
- Accidents
- Health and Safety
- Violent behaviour
- Challenging behaviour
- Personal and intimate care
- Moving and handling

- Tissue viability
- Physical interventions (formerly control and restraint)
- Sexuality and relationships
- Control and administration of medication
- Handling service users' money
- Risk assessment and management

These are cross-referenced with the 'Safeguarding Adults' procedures.

4.14 Health and social care providers ensure that every service user's care plan is cross-referenced to safeguarding issues. Where such issues have been identified they include a risk assessment in relation to the person's safety and any risk they may pose to others. The method of addressing any risk is clearly documented. Where appropriate, a joint risk assessment process should be used, such as a Care Programme Approach (CPA) lead risk assessment or a meeting held under the local Multi-Agency Public Protection Arrangements (MAPPA).

4.15 Incidents in which a service user has been at risk of harm, or has been harmed, are reported and monitored by each service provider. Where appropriate a referral is made to the 'Safeguarding Adults' procedures and to the commissioning organisation and the appropriate regulatory body, in accordance with current regulations.

GOOD PRACTICE EXAMPLE
National Patient Safety Agency (NPSA)

Seven Steps to Patient Safety

1. **Build a safety culture**
   Create a culture that is open and fair.
2. **Lead and support your staff**
   Establish a clear and strong focus on patient safety throughout your organisation.
3. **Integrate your risk management activity**
   Develop systems and processes to manage your risks, and identify and assess things that could go wrong.
4. **Promote reporting**
   Ensure your staff can easily report incidents locally and nationally.
5. **Involve and communicate with patients and the public**
   Develop ways to communicate openly with and listen to patients.
6. **Learn and share safety lessons**
   Encourage staff to use root cause analysis to learn how and why incidents happen.
7. **Implement solutions to prevent harm**
   Embed lessons through changes to practice, processes or systems.

Prevention of abuse and neglect

4.16 Each partner organisation carries out regular reviews of any such reports received and undertakes a root cause analysis if appropriate. Where appropriate, a referral is made to the 'Safeguarding Adults' procedures.

4.17 Commissioners and regulators regularly audit reports of risk of harm and require providers to address any issues identified. Where there is a series of minor incidents, a root cause analysis is carried out. Where this is appropriate, a referral is made to the 'Safeguarding Adults' procedures.

4.18 Commissioners actively liaise with the 'Safeguarding Adults' partnership and regulatory bodies and make regular assessments of the ability of service providers to effectively safeguard service users. This assessment is included as a key factor in their decision-making.

4.19 Each organisation uses current best practice recruitment systems consistent with its professional standards. It identifies employees and volunteers for whom CRB checks, enhanced CRB and POVA checks are appropriate and implements any relevant post-Bichard vetting scheme. Prospective employees account for the whole of their employment/ unemployment history and references are checked carefully.

4.20 Each organisation has a code of conduct in place in place for all staff and volunteers, setting clear standards for relationships between people in a position of trust and service users. These should be compatible with the law (e.g. Sexual Offences Act 2003) and professional standards e.g. of the Nursing and Midwifery Council (NMC) and the General Social Care Council (GSCC).

4.21 The organisation ensures that all staff and volunteers are able to identify and report concerns of abuse or neglect – *see Standard 5 Training.*

4.22 There is a clear process known to staff for action in response to concerns or allegations that a member of staff has perpetrated or contributed to abuse. This includes the process for suspension, transfer to a non-care position or supervised work on a precautionary basis, and interface with any police investigation.

4.23 All allegations that a member of staff has committed a crime (e.g. assault, harassment, theft) are reported to the police.

4.24 Managers, staff or volunteers who are dismissed because it is believed they have harmed a 'vulnerable adult' (whether or not in the course of their employment), or leave/resign when they may have been dismissed on these grounds, are referred to the POVA list (if their employment is covered by POVA see DH website for further information).

4.25 Adults who employ support or care workers through direct payments must have access to information about an employer's rights and responsibilities in relation to employees who are abusive, and must have access to support to address these issues if needed.

4.26 The partnership links with organisations that are not subject to regulation or contractual obligations and encourages them to achieve these Standards.

Standard 5 Training standards

It is the responsibility of each organisation to ensure that it has a workforce development plan that includes appropriate competencies of staff and volunteers in relation to 'Safeguarding Adults' work. Staff will need different competencies depending on whether, for example, they are frontline staff or managers. All people working in the organisation must be able to recognise abuse and neglect and know how to make effective reports.

Whilst this is an individual organisational responsibility, 'Safeguarding Adults' is a multi-agency task. It is therefore of great benefit if staff who will be liaising with colleagues in other agencies can take part in multi-agency courses that promote understanding of the roles of other partners.

The 'Safeguarding Adults' partnership can play a key role in enabling organisations to plan and commission such training together.

Standards

5.1 The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group.

5.2 The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.

5.3 The partnership has established standards and agreed competencies for the delivery of all 'Safeguarding Adults' training which is delivered locally.

5.4 Partner organisations jointly commission multi-agency training to meet common needs. This must include training for those undertaking specific roles within the procedures (e.g. safeguarding managers – *see Standard 9*)

5.5 Equality and diversity issues and the role of discrimination in supporting abuse and neglect is integrated into training courses.

5.6 The partnership's training strategy includes training that is accessible to and/or specifically tailored for service users and carers e.g. 'how to make a complaint about abuse or neglect'.

5.7 Multi-agency training meets the relevant national occupational standards for all of the target audience (e.g. NQF/Skills for Care, LDAF, PQSW).

5.8 There is a central database of everyone who has attended 'Safeguarding Adults' training; this is audited to plan and target training courses e.g. at particular staff groups.

5.9 Each organisation ensures that staff and volunteers at all levels have appropriate knowledge of and competencies in relation to the:

- potential for occurrence of abuse or neglect
- identification of abuse and neglect
- 'Safeguarding Adults' policy and procedures
- requirement to report any concerns of abuse or neglect
- internal reporting structure for such concerns

Prevention of abuse and neglect

5.10 Each organisation has a workforce development plan that includes competencies in relation to 'Safeguarding Adults' and audits the plan for reporting to the partnership on an annual basis.

5.11 Each organisation has established 'Safeguarding Adults' competencies for each staff role and enables staff to access successive levels of training in line with their personal and professional development. Where appropriate this training is mandatory.

5.12 Every member of staff is made aware of how they can use their routine processes (e.g. single assessment, risk assessments, care planning, triage) to enable people to acknowledge that they are at risk of abuse, and signpost them to effective support.

5.13 All training delivered 'in-house' (or commissioned by external providers for a partner organisation) is consistent with the local 'Safeguarding Adults' policy and procedures, as well as with relevant national standards.

5.14 Local providers of further and higher education courses to criminal justice, health and social care professionals include 'Safeguarding Adults' in their curriculum.

GOOD PRACTICE EXAMPLE (KENT)
Adult protection training structure for staff

Level 1: *Awareness*
Developing a shared understanding of what is abuse and what is a vulnerable adult. An understanding of the signs and symptoms of abuse. Also what to do if you witness abuse or are told about it.

Level 2: *The Practitioner's role*
Dealing with disclosures for those who need to complete the alert form as part of their professional role. Determining risk, vulnerability, and seriousness. Examining the implications of the three 'C's' – capacity, consent and confidentiality.

Level 3: *The Investigator's guide*
Knowledge and skills required in planning and undertaking a protective and/or detective investigation either within a single agency or jointly with colleagues from other agencies. Examining elements of good practice in gathering evidence.

Level 4: *Joint working and criminal investigations*
Developing mutual understanding of the complimentary and supportive roles of the police, social services and other agencies when a potential crime has been committed. This will include an overview of the 'Achieving Best Evidence' model of interviewing.

Level 5: *Decision-making*
This course is directed at those who will be involved in the conclusive decision-making processes (such as care conferences and planning meetings) and have responsibility for these under the current policy and procedures. Evaluating the evidence and implementing protection planning.

Level 6: *Post-abuse*
Who are the stakeholders in protection planning? Providing for the post-abuse support needs of the vulnerable adult and their support networks – a strengths and needs model. Managing the impact of adult protection on the practitioners. (This course is still in the process of being developed.)

Responding to abuse and neglect

Standards 6,7,8 and 9

As stated in on page 5, the primary responsibility of the 'Safeguarding Adults' partnership is to enable all adults *"who is or may be eligible for community care services"* to access appropriate services if they need support to live a life that is free from abuse and neglect. The framework for enabling adults to access such support is referred to in this document as the 'Safeguarding Adults' Procedures.

They should ensure that those adults *"who is or may be eligible for community care services"*, and who may be experiencing abuse or neglect, receive an assessment of the risk they are facing. Where they face a critical or substantial risk to their independence and wellbeing, community care services should be considered as part of a safeguarding plan. Where the assessment does not lead to community care services being provided or purchased other appropriate services should be signposted.

The procedures should be based on the presumption of mental capacity (Mental Capacity Act 2005) and on the consequent right of such adults to make their own choices in relation to safety from abuse and neglect - except where the rights of others would be compromised (see below). The specific choices available to a person will depend on the eligibility criteria for each service, but the baseline is that all people are supported to access information about the options that are open to them.

The most relevant aspect of mental capacity is that of understanding and making decisions about safety from abuse and neglect. Making this decision includes having information about what is taking place, the harm that it may cause and the options that are open to stop abuse or neglect, or to reduce harm. It includes weighing up that information and communicating the decision. Everyone has a right to follow a course of action that others judge to be unwise or eccentric, including one which may lead to them being abused. Where a person chooses to live with a risk of abuse the safeguarding plan should include access to services that help minimise the risk.

It is clear that any safeguarding action should usually be taken in consultation with the adults concerned, and that it should be taken in a manner that does not usurp their own choices or decision-making. It is also important that decisions made at any one time are not taken to be irrevocable and non-negotiable. Action must ensure that when adults with mental capacity take decisions to remain in abusive situations, they do so without intimidation, with an understanding of the risks involved and have access to appropriate services if they should they change their mind.

For "people who are eligible for community care services" and who have mental capacity, 'Safeguarding Adults' procedures should enable them access to mainstream services that will support them to live safer lives - as well as providing specific services to meet additional needs. For example, some adults have impairments which mean that they need assistance to overcome current barriers to existing services, in order to choose how to achieve a safer life. An example of this type of response is given on page 37 *(Standard 9, Story 1).*

Responding to abuse and neglect

GOOD PRACTICE (DEPARTMENT of HEALTH 2002)
Fair Access to Care: Eligibility criteria framework for adult social care

Level of risk to independence	Impact of risk
Priority 1 **Critical**	**Life is, or will be, threatened;** and/or ■ significant health problems have developed or will develop; ■ **there is, or will be, little or no choice and control over vital aspects of the immediate environment;** ■ **serious abuse or neglect has occurred or will occur;** ■ there is, or will be, an inability to carry out vital personal care or domestic routines; ■ vital involvement in work, education or learning cannot or will not be sustained; ■ vital social support systems and relationships cannot or will not be sustained; ■ vital family and other social roles and responsibilities cannot or will not be undertaken.
Priority 2 **Substantial**	■ **There is, or will be, only partial choice and control over the immediate environment; and/or** ■ **abuse or neglect has occurred or will occur;** ■ there is, or will be, an inability to carry out the majority of personal care or domestic routines; ■ involvement in many aspects of work, education or learning cannot or will not be sustained; ■ the majority of social support systems and relationships cannot or will not be sustained; ■ the majority of family and other social roles and responsibilities cannot or will not be undertaken.
Priority 3 **Moderate**	■ There is, or will be, an inability to carry out several personal care or domestic routines; and/or ■ involvement in several aspects of work, education or learning cannot or will not be sustained; ■ several social support systems and relationships cannot or will not be sustained; ■ several family and other social roles and responsibilities cannot or will not be undertaken.
Priority 4 **Low**	■ There is, or will be, an inability to carry out one or two personal care or domestic routines; and/or ■ involvement in one or two aspects of work, education or learning cannot or will not be sustained; ■ one or two social support systems and relationships cannot or will not be sustained; ■ one or two family and other social roles and responsibilities cannot or will not be undertaken.

For some adults, their impairments mean they need proactive support to understand that they have a choice to live a safer life; to understand the options open to them; and to choose which, if any, services they want to access in order to do so. An example of this type of response is given on page 40 *(Standard 9, Story 3).*

For other adults, even with support, their impairments mean that they do not have mental capacity to make such decisions. The capacity of some adults may fluctuate and they may not be able to make a decision about how to pursue their safety at the time it is needed. In such situations organisations must take positive action to ensure that such decisions are made on the person's behalf. This must be by a person or an organisation, acting in the best interests of the adult concerned (and, if appropriate, on what is known of their wishes prior to losing capacity). An example of this type of response is given on page 40 *(Standard 9, Story 4).*

The wishes of an adult with mental capacity should normally be respected. However, statutory agencies must act to uphold the human rights of all citizens and where others are at risk this duty will take precedence.

Any action taken by an organisation to safeguard an adult should meet Human Rights standards. It should be proportionate to the perceived level of risk and seriousness. Intervention should not be arbitrary or unfair. It must have a basis in law: e.g. acting with the consent of the adult or, under duty of care, acting in the best interest of the adult; undertaken to secure a legitimate aim (i.e. to prevent a crime or protect the public) and be necessary to fulfil a pressing social need.

Raising concerns about abuse or neglect nearly always involves sharing information about an individual that is both personal and sensitive (Data Protection Act 1998). Such information about an adult with mental capacity should be shared only with their informed consent, unless there is an overriding duty such as a danger to life or limb, or risk to others. These exceptions are described in the Data Protection Act (1998) and 'Caldicott guidance' (DH 1997), and case law in relation to human rights legislation. Information about an adult who may be at risk of abuse or neglect must be shared only within the framework of an appropriate information-sharing protocol.

Information about a potential perpetrator of abuse must also be shared under an appropriate information-sharing protocol. Local provisions such as MAPPA meetings and national provisions such as the POVA and POCA lists should be used.

Standard 6 Upholding Human Rights

Standards

6.1 All citizens can access information about how to gain safety from abuse and violence, including information about the local 'Safeguarding Adults' procedures *(see Standard 10).*

6.2 Any organisation which receives a report that an adult may be experiencing abuse or neglect responds in a positive and proactive manner.

6.3 Any person reporting abuse or neglect of an adult is effectively signposted to an appropriate source of information and advice about what options are open to them.

Responding to abuse and neglect

6.4 All reports of potential abuse or neglect of a person *"who is or may be in need of community care services"* made to or within any organisation are referred to the local 'Safeguarding Adults' procedures.

6.5 The 'Safeguarding Adults' policy and procedures are consistent with the principles and legal frameworks provided by the Human Rights Act and the Mental Capacity Act 2005.

6.6 Where a report is made that an adult *"who is or may be in need of community care services"* may be experiencing abuse or neglect, the person is contacted before the end of the next working day – unless this would place them at greater risk- and an assessment of risk to their safety is made. Where a crime has been committed this should be discussed with the police as soon as possible in line with the 'Safeguarding Adults' procedures.

6.7 There are systems in place for an appropriate assessment to be carried out, when necessary, as to whether a person has the mental capacity to make decisions about achieving safety from abuse or neglect.

6.8 Where an adult does not have mental capacity to make decisions about protection from abuse action should be taken to protect them. Any such action must be proportionate to the level of risk and take any knowledge of the person's previously expressed wishes into account.

6.9 Where a person who may be experiencing abuse or neglect has mental capacity, action is taken to enable them to choose to be in contact with an appropriate person; who can give information about options available and any actions that will be taken under overriding duties of organisations.

6.10 If a report is made that a service being provided is not safe (e.g. where a member of staff may be abusing service users, one service user is abusing another(s) or the service is run in such a way as to cause neglect), immediate positive action is taken to assess any risk and to appropriately enhance the safety of all service users.

6.11 Where an alleged perpetrator *"is or may be eligible for community care services"* (for example, if they are another service user or a carer) the procedures should include an assessment of the nature of the risk they cause and allow that any such assessment may result in the provision of community care services to the alleged perpetrator and/or sign posting to appropriate main stream services (e.g. anger management) as part of the safeguarding plan for the adult at risk.

6.12 There is an information-sharing protocol between all partner agencies, and those contracted to provide services by them, that covers all aspects of 'Safeguarding Adults' work. This includes the rights of adults to access data held about them.

6.13 The information sharing protocol includes the rights of an alleged perpetrator to know the nature of the concerns about their behaviour, to have a right of reply and have an opportunity to correct any information held about them that is not accurate.

6.14 The procedures give clear guidance as to action taken for the protection of human rights of those who were not the original subject of a referral. For example: abuse by a member of staff in a care setting; abuse of an adult in a domestic setting where children are present; violence or abuse that causes 'risk to life or limb' and abuse that is unacceptable on grounds of public interest - for example where a crime has been committed.

Standard 7 Joint systems

Standards

7.1 There is a local multi-agency 'Safeguarding Adults' policy and procedure describing the framework for responding to all adults *"who is or may be eligible for community care services"* and who may be at risk of abuse or neglect.

7.2 The procedure is part of a joined up network of strategies (e.g. domestic violence, hate crime, safeguarding children) giving a policy and procedural framework for responding to all reports that any person may be at risk of abuse or neglect.

7.3 The procedures are consistent with and refer to the multi-agency information-sharing protocol for 'Safeguarding Adults' work.

7.4 All partner agencies are signed up to the framework at senior executive/board level.

7.5 The process of writing and developing the procedures is carried out in partnership.

7.6 Frontline staff, volunteers, service users, carers and members of the public have been consulted within the process of developing the procedures.

7.7 The 'Safeguarding Adults' procedures set out clear pathways for responding, in partnership, to concerns of abuse or neglect and create a consistent standard of response to any abuse in all settings.

7.8 There is common documentation for reporting abuse and neglect that is consistent with the local Single Assessment Process (SAP) (DH 2001)

7.9 Each organisation has made explicit its potential roles, powers and duties in 'Safeguarding Adults' work and these are incorporated into the procedures.

7.10 The 'Safeguarding Adults' procedures include clear pathways that deliver effective protection services for all people covered by them across a range of different circumstances, experiencing any type of abuse or neglect in any setting.

7.11 The procedures include reference to the ADSS cross-boundary protocol specifying the responsibilities for co-ordinating 'Safeguarding Adults' work where care of an adult is contracted "out of area". Where such an adult may be experiencing abuse or neglect the safeguarding procedures of the area where the abuse is occurring should be followed. The placing authority maintains its responsibility to ensure that the care being provided meets the needs of the adult concerned.

7.12 The policy and procedures are accessible to all workers, service users, carers and members of the public, and are clear to understand.

7.13 The procedures are updated regularly and reviewed annually to incorporate lessons learned from practice *(see Standard 9)* and to include the most recent relevant legislation and guidance.

7.14 The framework includes a mechanism for resolving any disagreements between agencies, about how to work together to safeguard adults who may be at risk of abuse or neglect.

Responding to abuse and neglect

GOOD PRACTICE EXAMPLE (BRADFORD)

The District's multi-agency procedures divide adult protection situations into four types, to ensure that the pathway for each is consistent with the specific legal powers and statutory duties which apply to that situatiion in particular.

Mental Capacity Does the person experiencing abuse have mental capacity to make decisions about a 'Safeguarding Adults' assessment?	**Duty to protect others** Is the abuse occurring in a care setting? Is the alleged perpetrator a member of staff or volunteer? Are other service users at risk? NO	YES
YES	**Situation 1** A person with physical or sensory impairments is abused or neglected in their own home by a relative, friend, partner or stranger.	**Situation 3** A person with physical or sensory impairments is abused or neglected in their own home by a member of staff or a volunteer providing services Or Is abused or neglected in a setting where care is delivered, e.g. a hospital, day services, residential or nursing home.
NO	**Situation 2** A person without mental capacity, for example, with severe learning disabilities or dementia, is abused or neglected in their own home by a relative, friend, partner or stranger.	**Situation 4** A person without mental capacity, for example, with severe learning disabilities or dementia, is abused or neglected in their own home by a member of staff or a volunteer providing services Or Is abused or neglected in a setting where care is delivered, e.g. a hospital, day services, residential or nursing home.

Standard 8 Partner agency systems

8.1 Each partner agency has a set of internal guidelines, which are consistent with the local multi-agency 'Safeguarding Adults' policy and procedures and which set out the responsibilities of all workers to operate within it.

8.2 The internal reporting procedures for all partner agencies are stored centrally, e.g. with the 'Safeguarding Adults' co-ordinator, for reference by all partners and the partnership.

8.3 Where appropriate to its service, each organisation has integrated the possibility of risk of abuse and neglect into its assessment practice and risk assessment protocols.

8.4 Each organisation ensures that staff and volunteers at all levels have information, knowledge and training commensurate with their role in relation to 'Safeguarding Adults' *(see standard 5).*

8.5 All front line workers in all partner agencies are able to:

- effectively signpost any person seeking information about living a life free from abuse and neglect, and make appropriate referrals about child protection, 'Safeguarding Adults', domestic violence and hate crime
- identify people who may be able to receive services through the 'Safeguarding Adults' procedures
- recognise risks from different sources and in different situations e.g. risks from other service users, colleagues, relatives and carers
- accurately record facts, contemporaneously with any concerns of abuse or neglect, and actions taken as a result

8.6 All organisations have clear internal processes for staff and volunteers to gain information, support and advice on these issues.

8.7 Each organisation has a 'whistle-blowing' policy and procedure that is cross- linked to that of 'Safeguarding Adults', and is disseminated to staff and volunteers.

8.8 All agencies make staff and volunteers aware of external contacts to whom they can report concerns of abuse or neglect.

8.9 Each partner organisation ensures that staff and volunteers receive regular and recorded supervision that addresses 'Safeguarding Adults' issues and where there is an incident of alleged abuse or neglect, to debrief and reflect on practice. This should include the identification of and access to appropriate learning and development opportunities in this field.

8.10 Public bodies require agencies from whom they commission services to adhere to the local policy and procedures for 'Safeguarding Adults'. Commissioners monitor agencies to ensure that the policy and procedures are followed.

Responding to abuse and neglect

GOOD PRACTICE EXAMPLE (WEST SUSSEX)
Personal performance audit

To perform well in my Adult Protection (AP) role, I need...	Is this in place? Yes	No	Action I can take
a) a clear job remit with clear accountabilities			
b) clear multi-agency AP policy and procedures to follow			
c) clear standards to work to			
d) clear locally-agreed AP arrangements/ protocols within my agency			
e) clear locally-agreed arrangements/protocols between my agency and other agencies			
f) regular and clear feedback about how I'm performing this role			
g) regular supervision re-f) above, to share dilemmas and identify my development needs			
h) to know consequences if I don't do it well			
i) to know that adequate resources (e.g.time, people, services) are available			
j) to be able to prioritise critical AP tasks at critical times			
k) to know which people/ joint forums to feed emerging implementation issues to			
l) to develop my skills, expertise and knowledge by actually working on real cases, reflecting and learning from them			
m) to develop my skills, expertise and knowledge by sitting in/ observing/ shadowing/ finding a mentor/ talking to someone more experienced			
n) to develop my skills, expertise and knowledge by participating in off-the-job training			

Standard 9 Effective procedures

The aim of the multi-agency 'Safeguarding Adults' procedures is to enable people who are at risk of abuse or neglect to access safety. The Standards below follow a best practice procedure through all of its stages, including the decision as to whether a person is eligible for community care services to help them achieve a safer life.

Since the publication of 'No Secrets' the majority of local authorities have published multi-agency 'adult protection' procedures to help co-ordinate efforts which safeguard adults. A strength of 'No Secrets' was that it enabled local areas to evolve procedures, as the local partnership grew in understanding of the work and the needs in its area. These Standards draw on the strengths of many different local procedures.

However, a confusion arising from a process of local evolution is that areas use different language to describe similar procedures; **and** they may also have procedures which differ in their detail or their substance from that of their neighbours. This presents problems for partners working in regional and national organisations. The diversity also risks creating a 'postcode' lottery for accessing safety.

The Standards below are written in language that may not match the one with which the reader is familiar. For this reason, the language used to describe each stage of the procedures in this document is **bold maroon type**.

Standards

9.1 The multi-agency **'Safeguarding Adults' procedures** detail the following stages:

Alert	Reporting concerns of abuse or neglect which are received or noticed within a partner organisation. Any immediate protection needs are addressed
Referral	Placing information about that concern into a multi-agency context
Decision	Deciding whether the 'Safeguarding Adults' procedures are appropriate to address the concern
Safeguarding assessment strategy	Formulating a multi-agency plan for assessing the risk and addressing any immediate protection needs
Safeguarding assessment	Co-ordinating the collection of the information about abuse or neglect that has occurred or might occur. This may include an investigation e.g. a criminal or disciplinary investigation
Safeguarding plan	Co-ordinating a multi-agency response to the risk of abuse that has been identified
Review	The review of that plan
Recording and monitoring	Recording and monitoring the 'Safeguarding Adults' process and its outcomes

Responding to abuse and neglect

GOOD PRACTICE Based within the community care assessment time frame	
	Maximum time frame
Alert	Immediate action to safeguard anyone at immediate risk
Referral	Within the same working day
Decision	By the end of the working day following the one on which the safeguarding referral was made
Safeguarding assessment strategy	Within five working days
Safeguarding assessment	Within four weeks of the safeguarding referral
Safeguarding plan	Within four weeks of the safeguarding assessment being completed
Review	Within six months for first review and thereafter yearly

9.2 The procedures clearly delegate responsibility for the decision and for co-ordinating the safeguarding assessments, plans and reviews.

This responsibility is taken by professionals with appropriate levels of experience and skill to co-ordinate multi-agency working together. They may be employed by any of the partner organisations. It is their role to manage the 'Safeguarding Adults' process in relation to a safeguarding **referral**. In these Standards such people are referred to as **safeguarding managers.**

9.2.1 It is recognised and agreed that, whilst carrying out the role and duties of **safeguarding managers,** people are acting on behalf of the 'Safeguarding Adults' partnership and are accountable to it via their organisation.

9.2.2 **Safeguarding managers** receive specific training and support for the role.

9.2.3 Responsibility for co-ordinating the strategy process is clearly designated to an appropriate **safeguarding manager**

9.3 Standards for **the alert**

9.3.1 All agencies have an internal protocol for reporting and recording 'Safeguarding Adults' concerns.

9.3.2 The worker who first becomes aware of concerns of abuse or neglect ensures that emergency assistance, where required, is summoned immediately.

9.3.3 Where there is evidence that a crime has taken place the police are contacted.

9.3.4 Forensic and other evidence is not contaminated.

9.3.5 Any information given directly by the adult concerned is listened to and recorded carefully. However, the person is not questioned at this stage, to avoid creating unnecessary stress, through repeatedly describing events or creating a perception that they are not believed Such questioning can also risk the contamination of evidence.

9.3.6 The worker who first becomes aware of concerns of abuse reports them as soon as possible - and in any case within one working day - to the correct point within their own organisation.

9.3.7 A decision is made on that same day as to whether the situation should be referred to the multi-agency 'Safeguarding Adults' process.

GOOD PRACTICE

Receivers of alerts and referrals should respond by:

- remaining calm and not showing shock or disbelief
- listening carefully to what is being said
- not asking detailed or probing questions
- demonstrating a sympathetic approach by acknowledging regret and concern that what has been reported has happened
- ensuring that any emergency action needed has been taken
- confirming that the information will be treated seriously
- giving them information about the steps that will be taken
- informing them that they will receive feedback as to the result of the concerns they have raised and from whom
- giving the person contact details so that they can report any further issues or ask any questions that may arise

9.3.8 There is an agreed multi-agency format used by all partners for recording concerns of abuse. This collates information needed for the identification of repeat victims and multiple perpetrators and data needed to meet the monitoring requirements of the partnership.

9.3.9 Details of the report are recorded on the day it is made. It should be legible and of a photocopiable quality. The person making the report prints their name clearly and signs and dates it. Any opinions are clearly noted as such, and separated from the facts.

9.3.10 Information about the concerns are shared only within the framework of the 'Safeguarding Adults' information-sharing protocol.

9.3.11 The alleged abuser should not be contacted until there is an agreed **safeguarding assessment strategy** - unless this is part of emergency action needed to safeguard the adult or others at risk (e.g. an employer suspending staff in response to allegations against them).

9.3.12 Those alerting the abuse are supported, and involved appropriately in all stages of the process.

9.3.13 They receive confirmation that the concerns were raised and are being considered.

9.4 Standards for **the referral**

9.4.1 The referral point for 'Safeguarding Adults' concerns is simple and clear.

9.4.2 The referral point is accessible to members of the public, as well as to workers from all partner organisations.

Responding to abuse and neglect

9.4.3 Consent is gained for the referral from a mentally capable adult who is thought to be experiencing abuse or neglect unless there are overriding public duties to act or gaining consent would put the person at further risk.

9.4.4 If there are overriding duties, the person is informed that the referral will take place, except where this could jeopardise the safety of others who may be at risk.

GOOD PRACTICE Information recorded about concerns of abuse	
The adult(s) about whom the concern has been raised	Name(s) Contact information Communication and access needs Gender, race, faith, culture. What is known of their mental capacity and of their wishes in relation to the abuse/neglect.
The abuse or neglect that may be taking place place	How it came to light Its impact on the adult concerned The setting/occasion(s) where/when it took The alleged perpetrator(s), name and date of birth (if known) Any witness(es).
Any immediate action that was taken in response to the concern being raised	Any use of emergency services Crime number Any immediate safeguarding plan

9.5 Standards for **the decision**

9.5.1 Every referrer receives a clear response giving appropriate information about how the referral will be dealt with before the end of the next day. If the referrer is a partner organisation the feedback is recorded.

9.5.2 All adults covered by the 'Safeguarding Adults' policy who may be experiencing abuse or neglect receive a **safeguarding assessment.**

9.5.3 Where the adult is not covered by the policy, information is given or a referral is made to an appropriate service, and this action is recorded.

9.5.4 From the referral point, any concern about an adult covered by the policy is designated to the correct **safeguarding manager** within one working day of the referral.

9.5.5 Within the same working day the **safeguarding manager** decides if the referral is appropriate and records the decision.

9.5.6 There is a clear framework, agreed on a multi-agency basis, for deciding the level of urgency with which to pursue the next step of the procedures.

9.5.7 The **safeguarding manager** records the decision about the level of urgency.

GOOD PRACTICE

An assessment of urgency includes the presenting level of risk to the adult and incorporates:

- level of threat to independence
- impact of the alleged abuse on the physical, emotional and psychological wellbeing of the adult
- duration and frequency of the alleged abuse
- its degree and extent
- level of personal support needed by the adult, and whether that support is normally provided by the alleged perpetrator
- extent of premeditation, threat or coercion
- context in which the alleged abuse takes place

It is important to remember that, although a single event may create a serious risk to the person's wellbeing, it is often the accumulation of events - each of which may appear small - that causes serious harm.

9.5.8 Where immediate action is needed to protect the safety of one or more adults, information is passed to the appropriate person in the organisation(s) best able to implement those safeguards as soon as possible. This happens within the same day that the referral is received and the action is recorded by the **safeguarding manager** and by the partner organisation(s).

9.5.9 Where a child may be at risk, a referral is made to the safeguarding children procedures.

9.6 Standards for **the safeguarding assessment strategy**

Developing the strategy is a multi-agency process involving all those agencies appropriate to the particular situation. Sometimes the strategy can be made most effectively by a meeting of the relevant people (a 'Safeguarding Adults' **strategy meeting**). On other occasions it is necessary, and more effective, to formulate the initial strategy through a series of telephone conversations, e-mails, or through a virtual meeting (a 'Safeguarding Adults' **strategy discussion**).

9.6.1 Responsibility for co-ordinating the strategy process is clearly designated to an appropriate **safeguarding manager**.

9.6.2 Timing of strategy discussions reflect level of risk presented and in any case are completed within five days of a safeguarding **referral** being made.

9.6.3 There is a clear framework for deciding who is involved in **strategy discussions** for which situations.

9.6.4 There is an effective mechanism for convening and servicing a 'Safeguarding Adults' assessment **strategy meeting** if one is necessary.

9.6.5 The **safeguarding managers** make appropriate decisions about when to hold a face-to-face strategy meeting.

9.6.6 All relevant individuals and agencies are included in strategies.

Responding to abuse and neglect

9.6.7 Adults with mental capacity, who may be at risk, are involved as partners in the **strategy discussion** (with appropriate use of independent advocacy and victim support services), unless prevented by other considerations For example: for their safety; for the safety and rights of others (including the rights of an alleged perpetrator) or for the potential contamination of evidence.

9.6.8 Where such an adult with mental capacity cannot be included as a full partner the safeguarding manager should agree with them how their views are to be incorporated into the strategy-making process.

9.6.9 An alleged perpetrator would only be included in strategy discussions in very exceptional circumstances and with the agreement of the **safeguarding manager.** This must also be with the informed consent of the adult who is at risk (where they have mental capacity). Any such decision is clearly documented by the **safeguarding manager** and safeguards put in place to ensure any **safeguarding plan** is not jeopardised.

9.6.10 There is a clear framework of aims and outcomes for the **strategy discussion** that is shared in writing (or other durable accessible format) with all participants. These include: addressing immediate risk; a plan for carrying out of the **safeguarding assessment;** the rights, wellbeing and safety of people who may be at risk; and safeguarding the rights of 'whistleblowers'.

9.6.11 Where a crime is alleged to have taken place the police are involved as soon as possible and decide whether they will be taking action.

9.6.12 Where a service is implicated in abuse/neglect, a **strategy discussion** is held with the regulatory body and service commissioners; and a decision is made as whether the manager or the proprietor of the service is 'fit' to be involved in the strategy. This includes a judgement as to whether they are likely to be implicated as party to the abuse/neglect.

9.6.13 If the manager or proprietor is judged to be fit, they are included as a full partner in the **strategy discussions**.

9.6.14 During the discussion, all information known about the situation is shared in accordance with the information-sharing protocol with correct permissions sought.

9.6.15 Each organisation is proactive in offering resources within their remit to enable the risk of abuse to be assessed.

9.6.16 Actions agreed within the strategy are designated to the appropriate agency and worker.

9.6.17 Any investigation or assessment should be led by the agency with the appropriate legal powers and responsibilities. On some occasions joint investigations will be appropriate. A clear agreement between those agencies as to their respective roles should be part of the **strategy plan**.

9.6.18 Actions concerning people alleged to have perpetrated abuse are co-ordinated and action is planned to minimise risks to victims, witnesses and 'whistleblowers'.

9.6.19 The strategy aims for minimal interruption to the services being provided to an individual, or a group of people, during any **safeguarding assessment**.

GOOD PRACTICE EXAMPLE (SHEFFIELD)
(adapted and condensed)

Record of strategy meeting/ discussion in relation to an individual at risk

A COPY MUST ALWAYS BE SENT TO THE ADULT PROTECTION OFFICE

1. Date .... Venue .... Chair ....

2. Person's details:

Name:	DOB:	Age:	Gender: M / F
Ethnic origin:	Religion:	Language:	
Home address and telephone number:.	If living elsewhere, please state:		

3. Family composition including significant others eg carers:

Name	Relationship to subject	Dob	Address	Telephone number

4. Brief summary of details including; referral, source, time and date; contact to-date with subject and others: Supplementary sheets may be attached

5. Outcome of relevant agency checks concerning the subject:	Tick if relevant	Date of check	Result
Name of agency (e.g. GP, Police, SSD)			

6. Outcome of relevant agency checks concerning alleged perpetrator:	Tick if relevant	Date of check	Result
Name of agency (e.g. GP, Police, SSD)			

7. Give brief details in relation to the following:
   a) Are there any factors arising from the subject's cultural and or religious background which may have relevance for the safeguarding assessment?
   b) Are there any health or disability problems to consider in the safeguarding assessment?
   c) Is a specialist required to facilitate the safeguarding assessment?

8. Preliminary assessment of risk/unmet needs linked to threat to independence

9. Action to be taken – plan of how safeguarding assessment to be carried out:	Action	By whom		When		
10. Decision to interview subject:	Yes	No	Method of interview:	Video	Statement	
11. Decision to refer for medical assessment:	Yes	No	Decision pending			
12. Decision to convene Safeguarding plan meeting:	Yes	No	If no, state reason:			

13. Signatures and designations of decision makers:

14. Others present at meeting:

Responding to abuse and neglect

9.6.20 Repeat questioning of victims and witnesses is minimised.

9.6.21 The strategy includes a plan for communication between agencies during any safeguarding assessment.

9.6.22 The safeguarding assessment will include an interim safeguarding plan for the duration of the assessment. *See Standards for the* **safeguarding plan** *9.8*

9.6.23 The **safeguarding manager** ensures that accurate records/minutes are made of the strategy discussions or meeting and its outcomes which are circulated to everyone who has been part of the strategy discussions within five days of the strategy being completed.

9.7 Standards for **the safeguarding assessment**

9.7.1 A thorough assessment is made of risk level, including whether the alleged abuse or neglect has taken place.

9.7.2 Where the adult who may be at risk has mental capacity, they are usually the first person to be interviewed as part of the **safeguarding assessment/**investigation.

9.7.3 Their safety and confidentiality is paramount, except where information needs to be shared to protect others.

9.7.4 The communication needs, wishes and decision-making capacity of alleged victims are properly assessed and taken into full account, with appropriate use of independent advocacy and victim support services.

9.7.5 Forensic and other evidence is collected and preserved. Relevant files and documents are secured, using the appropriate powers of partner agencies where necessary.

9.7.6 Best evidence is achieved through victims being given protection and support regarding the criminal justice process, in line with the Youth Justice and Criminal Evidence Act (1999).

9.7.7 A decision is made by the police as soon as possible as to whether an Achieving Best Evidence interview is necessary and it is carried out within five days of the alert.

9.7.8 Individuals carrying out investigations on behalf of their organisation receive specific supervision and support (from it) in this role.

9.7.9 Each agency carries out the actions it agreed in the strategy discussion, and reports back to the **safeguarding manager** any changes to that plan.

9.7.10 Each agency makes comprehensive records of its work and the findings of any **safeguarding assessment/**investigation it carries out.

9.7.11 Each agency makes accurate records of its ongoing support and care of the adult(s) concerned.

9.7.12 Each agency reports promptly to the **safeguarding manager** any information that could change the plan agreed in the strategy.

9.7.13 The **safeguarding manager** co-ordinates an update **strategy discussion/**meeting if required.

GOOD PRACTICE
Lead role responsibility for investigations/assessments as part of 'Safeguarding Adults' procedures

Type of investigation/risk assessment	Agency responsible
Criminal (including, assault, theft, fraud, hate crime and domestic violence)	Police
Fitness of a registered service provider/manager	Commission for Social Care Inspection
Breach of Care Standards Act	Commission for Social Care Inspection
Unresolved serious complaint in a health care setting	Health Care Commission
Breach of rights of person detained under the Mental Health Act	Health Care Commission (Mental Health Act Commissioner)
Breach of terms of employment /disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of Health and Safety Legislation	Health and Safety Executive
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Service provider i.e. Manager/proprietor of service/complaints department
Breach of contract to provide care	Service Commissioner (e.g. Social services, Primary Care Trust, Supporting People)
Bogus callers or rogue traders	Trading Standards Officers
Misuse of public money	Local authority audit
Anti-social behaviour (e.g. harassment and nuisance by neighbours)	Anti-social behaviour team
Breach of tenancy agreement (e.g. harassment and nuisance by neighbours)	Landlord/Registered Social Landlord/Housing Trust
Misuse of Enduring Power of Attorney	Public Guardianship Office
Misuse of appointeeship or agency	Department of Work and Pensions
Inappropriate person or person making decisions about the care and wellbeing of an adult without mental capacity which are not in the adult's best interests	Court of Protection (from April 2007)
Assessment of need for health and social care provision (service users and carers)	Social Services/Primary Care Trust/Care Trust

Responding to abuse and neglect

9.8 Standards for **the safeguarding plan**

9.8.1 A clear framework exists for deciding who is invited to take part in assessing the results of the **safeguarding assessment/**investigation and in the **safeguarding plan.**

9.8.2 Each agency that had a role in the investigation/risk assessment makes a written report of that work, and these are considered on a multi-agency basis in a **safeguarding plan** meeting.

9.8.3 An adult with mental capacity, who has been reported to have been at risk, is included in the assessment of risk and the **safeguarding plan.**

9.8.4 Reports of **safeguarding assessment/**investigations are made accessible to the adult(s) concerned prior to the meeting, with the involvement of a family member or advocate if appropriate.

9.8.5 Where an adult does not have the mental capacity to be included, a person acting in their best interests, for example and advocate, key worker or relative, is nominated to take part in the risk **assessment** and **safeguarding plan.**

9.8.6 A multi-agency decision is taken as to the outcome of the **safeguarding assessment**/ investigation. This includes whether abuse/neglect took place, that it didn't, or that this is still not known **and** whether or not there is thought to be ongoing risk of abuse or neglect.

9.8.7 Where abuse has taken place, or an ongoing risk of abuse is identified as existing, a **safeguarding plan** is agreed with proactive steps to prevent further abuse and/or to decrease the risk.

9.8.8 Where abuse has taken place, there is active consideration in consultation with the police and legal services, of the potential use of relevant legislation.

9.8.9 Any person who is entitled to 'special measures' under 'Achieving Best Evidence' is identified as soon as possible and a referral made to Witness Support services.

9.8.10 Positive actions are planned/in progress to prevent the perpetrator from abusing or neglecting in the future.

9.8.11 Positive actions are planned to safeguard the adult and to promote recovery from further abuse/neglect.

9.8.12 Appropriate feedback, agreed at the **safeguarding plan** meeting, is given to those who report abuse or neglect concerning the outcome of their alert.

9.9 Standards for **the review**

9.9.1 A timescale for the review of the effectiveness of any **safeguarding plan** is agreed and recorded agreed at the safeguarding plan meeting, and in any case takes place within six months.

9.9.2 Any changes in circumstances made result in appropriate changes being to the safeguarding plan.

GOOD PRACTICE
Positive Actions

Actions to prevent repeat abuse or neglect by a person or an organisation

- Criminal prosecution
- Enforcement action by the Commission for Social Care Inspection
- Cancellation of registration of a care provider
- Application for a court order e.g. restraining contact or an anti-social behaviour order
- Application to the Court of Protection to change a Continuing or Enduring or other Power of Attorney or Receivership
- Application to the Department of Work and Pensions to change appointeeship or agency
- Civil Law remedies e.g. suing for damages
- Prosecution by Trading Standards
- Disciplinary procedures by an employer
- Referral to the POVA list (by an employer or CSCI of a manager/ provider)
- Referral to registration body (e.g. NMC, GSCC, BMA)
- Training needs assessment and supervision (of employee/volunteer)
- Organisational review e.g. of staffing levels, policies. procedures, working practices and culture
- Increased observation of and appropriate interventions to prevent abusive behaviour by other service users
- Changing service provision to a person who harms other service user(s) so that they are not in a position to continue abusing them
- Carrying out a carers assessment and providing services that decrease the risk of abuse
- Change of support services provided to an adult to decrease carer stress
- Access to behaviour change programmes
- Meeting with an individual who has caused harm, to negotiate changes in their behaviour

Actions to promote the safety of an adult and for recovery from abuse or neglect

- Security measures e.g. door locks and entry devices, personal alarms, telephone or pager, CCTV.
- Activities that increase a persons capacity to protect themselves
- Activities that increase self esteem and confidence
- Activities that increase health and wellbeing
- Advocacy services
- Victim support services
- Support to give Best Evidence in Court
- Counselling and therapeutic services
- Application to the Court of Protection for an appropriate person to make decisions on behalf of a mentally incapacitated adult (from April 2007)
- Application to the Court of Protection for an appropriate person to act as a receiver and manage the person's finances
- Application for Criminal Injuries Compensation

Responding to abuse and neglect

9.10 Standards for **recording and monitoring**

9.10.1 Each organisation keeps comprehensive records of any work that it undertakes under the 'Safeguarding Adults' procedures, including all alerts it receives and all referrals made.

9.10.2 There is an agreement on how and where the records of multi-agency work carried out under these procedures are stored.

9.10.3 The **safeguarding manager** ensures that comprehensive records are kept of any multi-agency processes and outcomes that they manage, and this information is stored securely according to the agreement in the procedures.

9.10.4 There is a protocol detailing the length of time for which records are to be held in line with national requirements.

9.10.5 There is an agreed process for, and resources allocated to, collecting, processing and monitoring all 'Safeguarding Adults' work undertaken under the procedures.

9.10.6 This process conforms to current national requirements for individual partner agencies and the partnership (cf. work in progress DH/AEA) for the collation for information about 'Safeguarding Adults' work and includes the number of referrals and their outcomes.

9.10.7 Information about "repeat" victimisation should be monitored and reported to the Crime and Disorder Reduction partnership as well as to the 'Safeguarding Adults' Partnership.

9.10.8 Monitoring information is collected and processed and feedback to the 'Safeguarding Adults' partnership on a regular basis.

9.10.9 There is a clear ongoing process for quality assurance of the multi-agency procedures.

9.10.10 Each organisation has a protocol by which to report any particular issues or difficulties and examples of good practice. These are communicated to the 'Safeguarding Adults' partnership in a timely manner.

9.10.11 The 'Safeguarding Adults' procedures are reviewed at least annually and changes are informed by quality assurance information.

9.10.12 The partnership has agreed processes for addressing difficulties in relation to delivering the 'Safeguarding Adults' procedures in particular cases, and for addressing general problems that arise.

9.10.13 There is an agreed multi-agency protocol for reporting any situations in which an adult covered by the procedures has died or been seriously harmed due to abuse or neglect to the partnership.

9.10.14 There is multi-agency agreement as to which other situations should be considered for a serious case review and how the decision will be made.

9.10.15 There is a clear process for commissioning and carrying out of a serious case review by the partnership *(see also standard 1.22).*

Case examples

The following 'stories', based on real cases, have been collated from around the country. They illustrate good practice for implementing 'Safeguarding Adults' procedures.

MAHI - STM - 101 - 006221

GOOD PRACTICE: STORY 1 An adult with capacity in a domestic setting	
Alert	Thomas's sister rang the adult protection unit. Thomas had a road traffic accident and now uses a wheelchair. After he received compensation his estranged wife Melanie moved back to live with him and told him she would "look after" him. Thomas has told his sister that Melanie does not provide personal assistance, shop, or cook food. He can't get out of his flat without assistance. Yesterday she pushed him down the stairs. He is hungry.
Referral	The unit contacts the safeguarding manager in the social work teams for disabled people, who rings the referrer.
Decision	The safeguarding manager agrees this is a situation covered by the procedures.
Safeguarding strategy	Thomas's sister and brother-in-law bring him to their house. A social worker speaks to Thomas on the phone at his sister's and arranges to visit. He is adamant that he does not want the police involved.
Safeguarding assessment	Thomas says that Melanie is clearly only interested in spending his compensation money and does not want to care for him. He rings the bank and finds out that there is only £416 in his account. He wants help to gain adapted housing so he can be independent.
Safeguarding plan	Thomas reluctantly agrees to live in a nursing home for disabled adults whilst his housing application is considered. He contacts the bank, takes Melanie's name off his account and changes his pin number.
Review	Six weeks later Thomas has an offer for a property that will need further adaptation. He has advertised for a personal assistant who he will pay through direct payments. He is keen to move but happy that he has made a good friend in the home and found out from other residents about local resources for disabled people. Melanie came to visit to "make up" but he told her that he did not want to see her.

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Responding to abuse and neglect

GOOD PRACTICE: STORY 2
A carer

Alert	Alicia is 62. Her adopted son Michael is 30. He has a learning disability and attended "special school" and then a residential college. Since he left college 3 years ago he has been living at home. The plan was for him to move into supported accommodation but he has refused to do this. Alicia's neighbours have rung the Learning Disability care management team because they are worried that Alicia isn't coping. When a care manager telephones Alicia she says she is scared of Michael and can't cope much longer.
Referral	The care manager discusses this with her team manager who is a safeguarding manager.
Decision	The safeguarding manager agrees this is a situation covered by the procedures
Safeguarding strategy	Care manager and Behaviour team worker visit Alicia on a day that Michael is at work. Manager of Michael's work placement has told care manager that he has been great at work and there are no problems.
Safeguarding assessment	Alicia is very tearful and ashamed. She does manage to tell the workers that when Michael doesn't want to do something or gets frustrated he throws objects and smashes them, throws himself on the floor, screams and bites any one who goes near him. He keeps asking her to let him go out to the local pub. She doesn't want him to go as she thinks he won't be safe. He has started to threaten her when he wants something, usually money which she doesn't always have, and has held her up against a wall once.
Safeguarding plan	Alicia agrees to make a statement to the police who interview and caution Michael. The care manager, work place manager and a housing support worker meet with Michael at his work place and he agrees to visit some prospective tenancies. The care manager meets with Alicia and Michael and supports them to make an agreement about money and behaviour.
Review	Three months later Michael has moved to a supported tenancy near Alicia's house. He is learning to manage his own money. Alicia has been to stay with her sister for a week and says she is starting to get her own life back again.

GOOD PRACTICE: STORY 3 An adult with limited capacity in a domestic setting	
Alert	Mr Myrcha is 82 years of age. His short-term memory is poor; he is lonely and anxious about money. He has a twice weekly visit for a domiciliary care agency contracted by Social Services. Mr Myrcha told one of the care workers that he feared he had been robbed. His friend Anne manages his money for him.
Referral	Care worker tells her manager who contacts Social Services, where safeguarding manager informed.
Decision	Adult protection procedure is appropriate.
Safeguarding strategy	Police Vulnerable Victims Co-ordinator contacted – agrees to visit Mr Myrcha together with a social worker.
Safeguarding assessment	Mr Myrcha says £800 is unaccounted for. An "old friend" had visited him but he could not recall why. He has a safe but it is broken and he leaves his curtains open at night to make use of the street lighting and save money. He trusts Anne.
Safeguarding plan	"Target hardening" measures taken. Door entry system installed. Vetted handyperson scheme employed to carry out gardening and maintenance work. Mr Myrcha signs enduring power of attorney with Anne as attorney. Anne asked to keep full record of all transactions. He starts attending day care.
Review	Mr Myrcha is still anxious but less lonely. No reports of alleged theft received since safeguarding plan introduced. Day care to monitor and call review if needed.

GOOD PRACTICE: STORY 4 An adult without capacity in a domestic setting	
Alert	When Zahida Begum (born approx 1928) attended Day Care, a doctor observed severe bruising to her upper arms and face, thought to be of a non-accidental origin. Mrs Begum is very demanding but her husband Mr Mahmood refuses help, insisting he can cope. He is described as "attentive and caring".
Referral	Day care made referral to safeguarding manager (Team manager of Social work team).
Decision	Safeguarding manager decides that the Multi Agency Adult Protection Procedures should be followed.
Safeguarding strategy	Police informed. Agreed police will lead investigation. Mrs Begum admitted to respite care until police investigation complete.
Safeguarding assessment	Police photograph Mrs Begum's injuries and carry out interviews with her husband. Mrs Begum is very unsettled in respite placement. Family involved in case conferences. They are unhappy and want her home. At a case conference her husband states that "he might have slapped her". Police caution him.
Safeguarding plan	Changed medication makes Mrs Begum more settled. Mr Mahmood agrees to accept support from home care and planned respite. He has started to attend a support group for carers at the local community centre. His son is visiting more often and doing more of the shopping and helps with lifting his mother e.g. at bedtimes.
Review	Mrs Begum returns home. She is calm most of the time and Mr. Mahmood is not so stressed. Family are happy to talk through issues with allocated social worker. Police take no further action. Further review date set – 6 months.

GOOD PRACTICE: STORY 5
An adult with capacity in a care setting

Alert	Sheila is 52 and has physical impairments resulting from cerebral palsy. She has been resident in a care home since she was 19. She tells her key worker that another resident, Gary, has raped her. She says this is a reoccurrence of a problem that has been happening on and off for fifteen years.
Referral	Care home worker tells her manager but, when he does not take any action, she phones the adult protection unit who contacts the safeguarding manager.
Decision	Agreed adult protection procedures and to hold a strategy meeting.
Safeguarding strategy	Sheila has met with an advocate who represents her at the meeting. She has agreed to make a statement to the police. The police lead the investigation. The proprietor of the care home to meet with the manager and staff team to ensure that, until police are ready to interview him, Gary's movements are monitored wthin the home. Sheila is given a personal alarm that she can operate easily. Once Gary has been seen by police, Care managers and key workers to meet with other women residents individually and ask if anyone in the home has ever hurt them.
Safeguarding assessment	Gary alleged to have sexually assaulted three residents and one ex-resident over period of 15 years. Police statements taken.
Safeguarding plan	Gary remanded on bail to live in single person tenancy .SSD contract personal assistants to meet his care needs. Women offered counselling –agreed with CPS.
Review	Women preparing for forthcoming court case. Manager of care home suspended. Proprietor carrying out internal review. CSCI to receive report. Staff team split for and against Gary, Acting manager asks for AP unit to come and talk to staff team.

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GOOD PRACTICE: STORY 6 An adult without capacity in a care setting	
Alert	A home care agency worker tells her manager that she doesn't want to work alongside Dianne anymore. When questioned why, she reluctantly tells that Dianne is a bully and doesn't care about the people they visit. She described an older woman being left dangling from the hoist above the commode and a person's visit being missed because Dianne said they hadn't time to visit him.
Referral	Manager of the agency contacts CSCI who contacts the safeguarding manager.
Decision	Agreed adult protection procedures; strategy agreed by telephone.
Safeguarding strategy	Dianne suspended pending disciplinary investigation. Manager to write to relatives of people concerned informing them of the investigation. One of the people has a care manager involved. They will discuss the issue with that family. SSD who commissioned the service informed and agree with plan.
Safeguarding assessment	Evidence from Dianne and two other members of staff and the families taken by manager. Dianne interviewed.
Safeguarding plan	Despite Dianne denying wrongdoing, manager feels has sufficient evidence to dismiss her. and makes a referral to the POVA list. CSCI, SSD commissioners and safeguarding manager informed.
Review	CSCI inspection praises manager's robust disciplinary procedures and relationships with staff.

GOOD PRACTICE: STORY 7 Adults with and without capacity in care setting (nursing home)	
Alert	Relative makes complaint to SSD Commissioning services about resident not receiving personal allowance. District nurse finds resident without mental capacity, with a pressure wound, dehydrated and not on pressure relieving mattress.
Referral	Adult Protection Unit contacted by both and referred to safeguarding manager.
Decision	Safeguarding manager consults with CSCI who have also just received a separate complaint about levels of staffing at night. CSCI report home has several outstanding issues to address from last two inspections, including staffing levels and care planning. Agreed Adult Protection strategy meeting should take place. Police made aware of concerns.
Safeguarding strategy	Strategy meeting takes place involving CSCI, PCT, local SSD commissioning team, SSD reviewing team, care managers who are working with individual residents, representatives of neighbouring authority who also fund residents and the proprietor of the home. A number of named residents are identified where they or relatives have raised specific concerns.
Safeguarding assessment	Individual complaints to be followed up with meetings between residents (who have capacity), relatives (if appropriate) care managers and the manager of the home. Residents who have made complaints, who have no relatives/do not want them involved, to be offered advocacy service. Social Services and PCT to jointly review a sample of residents with high dependency needs. Commissioning services in two local authorities to undertake joint visit and review contracted resident's finances.
Safeguarding plan	Proprietor to ensure all residents' care plans are up-to-date and being implemented; resolve staffing issues as a matter of urgency; reissue information about complaints process to all residents and visitors, including information about how to contact SSD Commissioning and CSCI. District nurse team to deliver training on local pressure care management protocol to staff. CSCI to seek enforcement notice about standards not met. Both Local Authority contracts team suspend placements.
Review	Change of management at home. CSCI have carried out an inspection in relation to complaint about staffing levels and care plans and noted improvement in standards. Placements reinstated. Joint reviews continue to ensure all residents have appropriate care plans. Subsequent review date set to follow next CSCI announced inspection.

Access and involvement

Standards 10 and 11

'Safeguarding Adults' work is specifically aimed at a group of people who historically have been discriminated against within our society. This discrimination explains in part why the prevalence of abuse of people *"who are or may be eligible for community care services"* is high.

Discrimination on the grounds of disability or age may in itself contribute to or abuse or neglect. For example: a person having stones thrown at them and being called names or not providing care because "they have already had a good innings". Discrimination also prevents people accessing help and support to live safer lives. For example: a person with a mental health problem not being believed when they report abuse; deaf people not having information about how to complain about services.

There are other situations where discrimination on different grounds (e.g. gender, race, religion, sexuality) also contributes to abuse. For example: two men with learning disabilities being thrown out of supported accommodation when they started a sexual relationship with each other.

The group is diverse, and the content and impact of discrimination can vary with the details of people's impairments. It is important that specific efforts are made to ensure that the 'Safeguarding Adults' measures are accessible to **everyone** *"who is or may be eligible for community care services".*

The work of the 'Safeguarding Adults' partnership must be clearly linked to local strategies to address discrimination on the grounds of disability and age, as well as to those that address other issues such as race equality. The partnership must guard against institutionalised discrimination on these, or any other grounds.

The 'Safeguarding Adults' partnership must have a communications and engagement strategy. This should be appropriate for its local population and accessible to adults who are covered by the policy. An effective strategy will: raise awareness of 'Safeguarding Adults' work; ensure that all citizens are able to make self-referrals; and enable feedback about the relevance and efficacy of the work.

Standard 10 Equal access to safeguarding services

Standards

10.1 The safeguarding procedures are accessible to all adults covered by the policy

10.2 Monitoring of 'Safeguarding Adults' work by the partnership includes age, impairments/disability, gender, sexuality, ethnicity and faith identities.

10.3 Monitoring of access to 'Safeguarding Adults' services provided by individual organisations (e.g. use of 'Special Measures', recorded hate crime towards disabled people, number of referrals from GP surgeries) is carried out on the same basis.

10.4 Documentation used to plan, record and monitor safeguarding work in relation to an individual includes fields that prompt workers to consider the person's needs and preferences and to assess the impact of any intervention in relation to faith, race, culture, gender and sexuality.

10.5 The partnership carries out an annual impact assessment comparing this data to local population data.

10.6 The partnership has a strategy for addressing issues that are preventing some groups from accessing services to support a safer life.

10.7 Where needed, specific services are developed to enable everyone to access safety and support to recover.

10.8 The partnership has clear links to local partnerships which address 'Community Cohesion' and 'Equality and Diversity'.

GOOD PRACTICE EXAMPLES

Specific services

Beverley Lewis House

The Beverley Lewis House is a Safe House for Women with learning disabilities who feel frightened, or are being treated in a bad way and want it to stop. If you are being or have been attacked or treated in a bad way you can do something about it.

Contact: PO Box 7312, E15 4TS Tel: 020 8522 0675

Beyond Existing

Support groups for older and disabled people who have been abused

Many people, both men and women, are mistreated or harmed by someone during their lifetime. It is very hard for people who have been harmed to talk about it because they might feel ashamed, embarrassed (especially if it is a family member who has done something awful) or think that no-one is going to believe what happened to them. Adults can be mistreated or harmed physically, sexually, emotionally, or financially by family, friends, professionals, workers or strangers.

In the **Beyond Existing groups** members can talk in complete confidence, meet others who have been mistreated or harmed, have support from those with similar experiences and obtain advice if required. The groups are open to anyone aged over 18 years who has experienced abuse either in childhood or adulthood. Their main objective is to support people through the healing process and a variety of methods are used in the groups; discussion, exercises, drawing and creative writing. There have been mixed and single sex groups. Members have included adults with learning disabilities and those with mental health problems; with ages ranging from 20 and 93 years. We meet in West Yorkshire.

Beyond Existing, P.O Box 1779, Sheffield S6 3YB or Telephone: 0114 270 1782

Jewish Care and the London Borough of Barnet

Jewish Care is a voluntary sector organisation offering support and social care to Jewish people in London and South East England. The organisation has a social work team which carries out an assessment and care management function for Jewish service users on behalf of the London Borough of Barnet. Any referral concerning the abuse of a Jewish adult will involve both agencies working in partnership. This may involve a joint investigation under the direction of a multi-agency strategy meeting, which is chaired by the local authority. Any subsequent case conference will devise a culturally sensitive protection plan, and may involve some of the services provided by Jewish organisations. A number of these are available for Jewish service users including residential, nursing and home care provision. There are also specialist services for survivors of the holocaust, refugees and their families. Jewish Care is a member of Barnet's local Adult Protection Committee.

Access and involvement

Standard 11 Engaging citizens

11.1 The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service user participation into:

- its membership
- the monitoring, development and implementation of its work
- the training strategy
- the planning and implementation of their individual safeguarding assessment and plans.

11.2 Partner organisations build service user involvement into the design and delivery of safeguarding services

11.3 The policy is explicit in its promotion of the core values of promoting independence, respect, dignity and choice and interventions carried out under the procedures are consistent with this.

11.4 Feedback is sought from all individual service users and carers about the delivery and outcomes of safeguarding work for them. There is a mechanism for this feedback to inform improvements and developments.

11.5 The partnership recognises and promotes the value of community and neighbourhood networks in preventing abuse and protecting those who are at risk.

11.6 The partnership has an information and publicity strategy.

11.7 Information about 'Safeguarding Adults' work is produced using a wide range of accessible and user-friendly styles for the general public, specified communities of interest, service users and carers. A variety of different formats and media is used for dissemination e.g. community radio, public forums, internet, local newspapers, publications of partner organisations.

11.8 The information clearly outlines what abuse is and how to express a concern, who to contact/who to speak to.

11.9 There is a 'One Stop' contact for all concerns about abuse or neglect of an adult. This contact point is accessible through different forms of communication.

11.10 Publicity carried out by the partnership and by individual organisations is monitored, and an annual impact assessment is made e.g. by mapping types of information distributed against other data such as referrals to the procedures.

GOOD PRACTICE EXAMPLES (SUNDERLAND)

Publicity campaign

A city-wide publicity campaign was launched with the aim of raising the profile of adult abuse within the local community. The campaign was launched at an annual Adult Protection Seminar and was followed up by the distribution of revised public information leaflets and media coverage. The Adult Protection Committee worked in partnership with the local press to feature a variety of different posters and articles focusing on adult abuse. In developing the campaign, an extensive consultation process took place to ensure that views, ideas and suggestions from a wide range of groups and people were listened to and acted upon. This included service user groups and carers.

One Stop contact point

An adult protection helpline has been set up, which members of the public can ring to express a concern or simply to obtain advice or information with regards to adult abuse. The helpline has been set up within the Social Services Community Alarm Service and is staffed 24 hours a day. There is a direct link to the Adult Protection Unit and all referrals from the helpline are picked up by the Unit. The helpline is advertised in local magazines and through distribution of contact cards and leaflets.

Information that is accessible to people with a learning disability

The Adult Protection Committee worked in partnership with Sunderland People First (a self-advocacy group for people with learning disabilities) to develop an accessible adult protection guide for people with a learning disability. Members of the development group worked in consultation with service users from day services to produce a pictorial guide with 'easy to understand language'.

Relevant legal statutes

Abuse that is a crime

Common Law of Tort

Crime and Disorder Act 1998

Criminal Justice Act 1968

Domestic Violence Crime and Victims Act 2004

Family Law Act 1996

Medicines Act 1969

Offences Against the Person Act 1861

Police and Criminal Evidence Act 1970

Protection from Harassment Act 1997

Public Order Act 1986

Sexual Offences Act 1956

Sexual Offences Act 1967

Sexual Offences Act 2003

Theft & Deception Acts 1968 and 1978

Youth Justice and Criminal Evidence Act 1999

Other relevant statutes

Court of Protection Rules 1994

Data Protection Act 1998

Disability Discrimination Act 1998

Enduring Power of Attorney Act 1985

Health & Safety at Work Act, 1974

Human Rights Act 1998

Mental Capacity Act 2005

Power of Attorney Act 1971

Public Interest Disclosure Act 1998

Race Relations (Amendment) Act 2002

Social Security (Claims and Payments) Regulations 1987

Provision of health and social care services

Carer's (Recognition and Services) Act 1995

Carers and Disabled Children Act (2000)

Care Standards Act 2000

Chronically Sick and Disabled Persons Act 1970

Community Care (Direct Payments) Act 1996

Disabled Persons (Service Consultation and Representation) Act 1986

Employments Rights Act 1996

Health and Social Care Act 1990

Health Service and Public Health Act 1968

Health Act 1999

Housing Act 1985

Housing Act 1996

Housing Act 2004

Local Authority Social Services Act 1970

Mental Health Act 1959

Mental Health Act 1983

National Assistance Act 1948

National Assistance (Amendment) Act 1951

National Health Service Act 1977

National Health Service and Community Care Act 1990

Public Health Act 1936 and Public Health Act 1961

Registered Homes Act 1984

Registered Homes (Amendment) Act 1991

Glossary

Association of Directors of Social Services (ADSS)
A membership organisation which represents all the directors of social services and leaders of social care in England, Wales and Northern Ireland.

ADSS cross-boundary protocol.
An agreement stating that, although the commissioners of a service retain responsibility for the wellbeing of an individual placed 'out of area', any 'Safeguarding Procedures' in relation to abuse taking place in the host area should be managed by the host authority according to its local multi-agency procedures.

Audit Commission (AC)
An independent public body responsible for ensuring that public money is spent economically, efficiently and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services.

British Medical Association (BMA)
A voluntary professional association of doctors from all branches of medicine all over the UK.

Building community capacity
Development work that strengthens the ability of communities and community organisations to build local skills, structures, participation and solutions.

Carers
People such as family, friends or neighbours who provide unpaid support and care to another person.

Care programme approach (CPA)
The process which mental health service providers use to coordinate the care for people who have mental health problems.

Care trusts
Organisations that work in both health and social care. They may carry out a range of services, including social care, mental health services or primary care services.

Commissioners
The branches of health and social care statutory organisations that purchase services from voluntary and independent sector organisations - through which they provide additional health and social care services to the public.

Commission for Social Care Inspection (CSCI)
The single, independent inspectorate for all social care services in England.

Crime and Disorder Reduction Partnerships
The statutory multi-agency local partnerships formed in response to the Crime and Disorder Act 1998, as amended by the Police Reform Act 2002, to develop and implement strategies to tackle crime and disorder and misuse of drugs in their area.

Criminal Records Bureau (CRB)
An executive agency of the Home Office which helps employers in the public, private and voluntary sectors to identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

Direct payments
Financial resources given to people so that they can organise and pay for the services that they need, rather than use the services that the council offers.

Fair Access to Care Services (FACS)
Guidance issued by the Department of Health to councils and care trusts about fair charging policies for home care and other non-residential care, and advice about eligibility criteria for adult social care.

General Social Care Council (GSCC)
The social care workforce regulator. It registers social care workers and regulates their conduct and training.

Healthcare Commission
This promotes improvement in the quality of healthcare in England and Wales. In England this includes regulation of the independent healthcare sector.

Learning Disabilities Awards Framework (LDAF)
A set of qualifications appropriate to people who work in learning disability services.

Local area agreement (LAA)
This provides a single framework through which government departments can allocate additional funding to a local authority and its partners.

Local Delivery Plan (LDP)
The plan agreed by the DH by which Strategic Health Authorities and PCTs will deliver health services in partnership with other agencies.

Local Strategic Partnership (LSP)
Brings agencies and others together in a way which focuses and commits its members to improving the quality of life and governance in a particular area.

"is or may be eligible for community care services"
In general, councils may provide community care services to individual adults with needs arising from physical, sensory, learning or cognitive disabilities and impairments, or from mental health difficulties. In this regard, councils' responsibilities to provide such services are principally set out in the :

- National Assistance Act 1948.
- Health Services and Public Health Act 1968.
- Chronically Sick and Disabled Persons Act 1970.
- National Health Service Act 1977.
- Mental Health Act 1983.
- Disabled Persons (Services, Consultation and Representation) Act 1986.

Multi-agency Public Protection Arrangements (MAPPA)
A statutory set of arrangements operated by criminal justice and social care agencies that seeks to reduce the serious re-offending behaviour of sex and violent offenders to protect the public.

National Service Frameworks (NSFs)
A set of national standards and identify key interventions for a defined service or care group; put in place strategies to support implementation; and establish ways to ensure progress within an agreed timescale.

National Qualifications Framework (NQF)
The national framework for qualifications.

Nursing and Midwifery Council (NMC)
An organisation set up by Parliament to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients.

Partner agency
One of the organisations who is a member of a group of organisations working together in partnership to achieve common objectives.

Person-centred planning (PCP)
This is a process of life planning for individuals based on the principles of inclusion and the social model of disability.

Primary Care Trusts (PCTs)
The local health organisations responsible for managing local health services. PCTs work with Local Authorities and other agencies that provide health and social care locally, to make sure the community's needs are being met.

Post Qualification Social Work (PQSW)
The framework for post-qualifying awards for social workers.

Protection of Venerable Adults (POVA)
A list of those registered as being unsuitable to provide care to 'vulnerable adults'. Through referrals to, and checks against the list, care workers who have harmed a vulnerable adult, or placed a vulnerable adult at risk of harm (whether or not in the course of their employment), will be banned from working in a care position with vulnerable adults.

Public Concern at Work (PCaW)
An independent authority on public interest whistleblowing. Established as a charity in 1993 following a series of scandals and disasters, PCaW has played a leading role in putting whistleblowing on the governance agenda and in influencing the content of legislation in the UK and abroad.

Root Cause Analysis (RCA)
A retrospective review of a patient safety incident undertaken in order to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future. This approach is equally applicable to complaints and claims.

'Safeguarding Adults'
All work which enables any adult *"who is or may be eligible for community care services"* to retain independence, wellbeing and choice **and** to access their human right to live a life that is free from abuse and neglect.

'Safeguarding Adults' Partnership
The formal group of organisations (led by Social Services) who are working together to implement 'Safeguarding Adults' work in a local area.

Service provider
An organisation that delivers services, such as health and social care services.

Service User
A person who is a customer/consumer of a service (particularly used in relation to those using social care services).

Skills for Care
The organisation responsible for the strategic development of the adult social care workforce.

Single Assessment Process (SAP)
Introduced in the NSF for older people, it aims to make sure older people's care needs are assessed thoroughly and accurately, but without procedures being needlessly duplicated by different agencies.

Staff
People employed on a paid or unpaid (voluntary) basis by an organisation to organise and deliver its services/product.

Social Services Departments
The part of the Local Authority responsible for commissioning and providing social care services to adults and children.

Supporting People
A working partnership of local government, service users and support agencies which provides high-quality and strategically planned housing-related services.

Universal services
Services provided to the whole community. These can include education and health, libraries, leisure facilities and transport.

Voluntary and community sector (VCS)
Over half a million voluntary and community groups in the UK, ranging from small community groups to large national or international organisations.

Zero Tolerance
Non-acceptance of antisocial and especially criminal behaviour, with an emphasis on dealing effectively with every manifestation of the behaviour however large or small.

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Useful Websites

www.adss.org.uk
Association of Directors of Social Services

www.anncrafttrust.org
Ann Craft Trust, formally NAPSAC, is a UK based organisation working with staff in the statutory, independent and voluntary sectors in the interests of people with learning disabilities who may be at risk from abuse.

www.bgop.org.uk
'Better Government for Older People'

www.csci.gov.uk
Commission for Social Care Inspection

www.chi.gov.uk
Health Care Commission

www.cjsonline.org/citizen/victims
- information about the criminal justice system

www.crimereduction.gov.uk
Home Office Crime Reduction

www.dh.gov.uk
Department of Health

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics

www.elderabuse.org.uk
Action on Elder Abuse

www.homeoffice.gov.uk
The Home Office

www.informationcommissioner.gov.uk

www.mencap.org.uk
a leading learning disability charity working with people with a learning disability and their families and carers

www.pavauk.org.uk
Practitioner Alliance against Abuse of Vulnerable Adults

www.pcaw.co.uk
Public Concern at Work

www.thepowerhouse.org.uk
A safe house for women with a learning disability

www.refuge.org.uk
Refuge for women and children experiencing domestic violence

www.respond.org.uk
Providing Services to People with a Learning Disability who have experienced sexual abuse.

www.viauk.org
Values into Action. This is a national campaign for people with learning difficulties. This project is researching bullying and harassment of people with learning difficulties

www.victimsupport.org.uk
Victim Support is the independent charity which helps people cope with the effects of crime. We provide free and confidential support and information to help you deal with your experience.

www.voiceuk.org.uk
VOICE UK. We are a national charity supporting people with learning disabilities who have experienced crime or abuse. We also support their families, carers and professional workers

www.womensaid.org.uk
Women's Aid – for women and children experiencing domestic violence

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Appendix 5

MUCKAMORE ABBEY HOSPITAL RESPONSES TO THE DRAFT STANDARDS FOR THE INSPECTION OF CHILD PROTECTION SERVICES

Nov 05

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Values and Principles

A number of important themes have emerged from **policy and** legislation, **the** literature **reviews and research** and the consultation process which are reflected in the following **values** and **principles** statements.

1. Safeguarding and promoting the welfare of children at risk of abuse or neglect is a priority when decisions are made about access to and eligibility for services.

2. Listening to and engaging children and their families is crucial to ensure their full participation in decision-making which affects them.

4. Some children are particularly vulnerable due to their circumstances and the design and delivery of services promotes and safeguards their well-being.

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STANDARD1
The Board/Trust has arrangements in place for the planning, commissioning, monitoring and management, and provision of child protection services which meet the assessed needs of children and families.

Criteria	Indicators/Evidence	Hospital Action/Progress
1.1 The Board/Trust has established arrangements across the range of appropriate disciplines and agencies for resourcing and planning its child protection services.	Children's Services Plan (CSP); Departmental guidance cooperating to safeguard children. The lead role for child protection is fulfilled and statutory obligations are met. Written statements/guidance/minutes Check out in interviews with Managers/Board Members	Trust Child Protection Panel has representation from social work and now to include nursing from the hospital and the panel will consider hospital issues. Hospital to establish a subgroup that will include child protection nurse and community consultant paediatrician.
1.3 The Trust has agreed protocols, guidance and procedures for delivering and monitoring child protection services in its area.	Policies, procedures and guidance, which address all aspects and stages of the child protection process. Systems, which make explicit the role, responsibility, functions and accountability of those involved in case management and decision making.	The hospital has developed a protocol to meet the regional child protection guidelines and is keeping with the Trust protocol and cooperating to protect children.
1.8 The Board/Trust has a clear workforce strategy in place, which demonstrates that it has signed up to and conforms to codes of contact and	Workforce Strategy defines recruitment processes, skills, knowledge and experience required by staff working with children who need to	The Trust has a workforce strategy that outlines recruitment process, knowledge and skills of workforce, e.g.

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practice for employers and employees.	be safeguarded. Induction Programmes and Interviews Organisational Chart. Role and function of staff, level of responsibilities and accountability delegated to each level within the organization. (Presentation and Interviews) Supervision Guidance, Records and Interviews. Arrangements for staff development and post qualifying training. (Training Profiles and Training Needs Analysis, Interviews) How the effectiveness of training is evaluated (Evaluations) Appraisal and performance, (Documentation and Guidance) Guidance in regard to Caseload management and monitoring systems, quality and standard of recording practices. The requirements of the Protection of Children and Vulnerable Adults (NI) Order 2003 when selecting, recruiting, managing and retaining staff and volunteers who have access to children and reviews how it complies with social care governance, including codes of conduct for employers as part of their corporate responsibility.	Telford survey has been completed for nursing. Induction programmes are mandatory for all staff. Organisational chart is circulated to all wards/departments. Lines of accountability are clearly defined. Social work supervision guidelines have been issued. The Trust has a working group looking at supervision guidelines for all staff. KSF outlines have now been completed for staff. See 1.9 for training S.D.P.R is completed yearly for all nurses. This is currently being reviewed by a Trust working group. P.E.C.S and POCVA checks are carried out for all staff prior to employment and also for volunteers.

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1.9 All managers and staff within Boards and Trusts and relevant professionals in partner organisations have knowledge of child protection policy and procedures and of services available for the protection and support of children and families and can demonstrate that they have received training in child protection.	Training Plans Courses attended. Interviews demonstrate that individuals know the procedures and use of them. Case records	The hospital has a training record report that is regularly monitored by Senior Nurse Managers. This details information on training type, who and level required. EQC audits mandatory training for all disciplines social workers/day care are registered with NISCC and have a requirement for continuous professional development nursing meet the PREP requirements for N.M.C.
1.10 Child protection provision is located within a continuum of services to children in need and their families and include a range of interventions for the prevention and treatment of significant harm.	Range of services. Programmes within these. Indications in Care plans	Care plans are regularly reviewed for all children, multidisciplinary ward meetings occur weekly. LAC review on all under 18 years olds.
1.13 The Board/Trust regularly monitor and review complaints, representations, case management reviews and audits of practise.	These are used to: • Ensure satisfactory outcomes, • Learn from both positive and negative experiences, • Share and disseminate knowledge gained across disciplines and agencies and as appropriate throughout the region. Identify and take	Trust Complaints Review Committee monitors outcomes of complaints. Lessons learnt and the sharing of this and good practice is circulated quarterly by email to all staff. Multidisciplinary input to LAC reviews. Hospital procedure outlines

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	account of unmet need, • Inform the planning of services and allocation of resources, • Workforce planning, improve joint working arrangements and provide better focus on work with children and families, • Consider the input of different professionals to CPCC and review processes, • Consider the attendance of children and parents at CPCC and reviews; and • Consider the qualities of communication across staff/teams/offices/professionals. • Check out in interviews and in planning and service delivery arrangements	referral process to CPCC and preparation of reports and attendance.

STANDARD 2 **The Board/Trust has a written statement of purpose about its child protection services, including its statutory basis, availability, user entitlement and expected standards informed by the DHSSPS guidance 'Co-operating to Safeguard Children'. (May 2003)**		
Criteria	**Indicators/Evidence**	**Hospital Action**
2.1 The Board/Trust has written statements about the range of child protection services in its area. These set out the nature and purpose of the services provided based on statutory functions and responsibilities and informed by the guidance contained in "Co-operating to Safeguard Children".	Written information leaflets. Annual Reports.	The hospital is currently updating its information for parents/children in relation to child protection.
2.2 The Board/Trust has established clear priorities for its child protection services and the standards of services expected of staff.	Process/decision making.	The hospital child protection procedure outlines process and decision making. Policies and procedure have been developed on • Anti Bullying • Management of Aggression • Intimate Care
2.3 The Board/Trust staff are clear about their roles and responsibilities and are aware of statutory functions, DHSSPS guidance "Co-operating to Safeguard Children" and related policies and procedures.	Written guidance. Access to guidance/policy and procedures.	Staff are aware of policy and availability through the training and induction process. Copies are in all wards/departments.
2.4 The Board/Trust can demonstrate that they have been pro-active in making children and	Activities/Information	Advocacy for children with communication difficulties. This is to be discussed with other Trusts

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parents aware of how they can express their views about services.		re:VOYPEC etc.
2.5 Children and parents are aware of how they can express satisfaction with, or complain about, the response made to their needs and the reliability and quality of the services they receive.	Activities/Information	The hospital has a robust complaints procedure and processes are in place. Children and parents are encouraged to inform staff of any concerns or their satisfaction at ward level. This is documented in ward communication book, patient's notes and Senior Nurse Manager is informed. If a formal complaint is made this is directed to the Chief Executive's Office for a response. This is monitored through the EQC Audit.

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STANDARD 3

The Board/Trust promotes access to services by children and families and concerned members of the public where there are child protection concerns.

Criteria	Indicators/Evidence	Hospital Action
3.4 The Trust responds quickly and avoids undue delay in finding alternative placements where necessary for children in need of protection and provides choice to ensure individual needs can be met.	Range of provisions. Access to resources. Check in interviews and focus groups.	Adolescents in Adult Wards are risk assessed and supervision levels are agreed. Owning Trust notified.
3.6 Those who make referrals and enquiries about safeguarding children are responded to in a way, which ensures an appropriate response to the concerns raised.	Strategy-activity/process. Check in interviews and focus groups.	This would be investigated under child protection procedures. Community would be informed.
3.8 Public access, reception and duty arrangements, including out of hours or emergency arrangements, enable appropriate access to services and support.	Observations, interviews and focus groups Written Guidance	The child protection procedure lists names and contact details for all Trusts and Boards. The out of hours arrangements for social work contacts at Boards is available at reception and it is the role of Duty Nurse Manager to coordinate.

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STANDARD 4

***The Board/Trust* has written policies and procedures, which provide direction and guidance to staff. These are underpinned by effective supervision and management arrangements, and policies and procedures which detail expectations regarding assessment, case planning, case management and record keeping of individual cases at all stages of the child protection process.**

Criteria	Indicators/Evidence	Hospital Action
4.1 The Trust gives clear guidance to its staff in the form of written policies and procedures and has established agreed multi-agency guidelines.	Policies and procedures are based on DHSSPS guidance and evidence available from research and best practice and identify timescales and systems for: - the response to an initial referral/known case expressing concern about significant harm/welfare of a child which is prompt, thorough and proportionate; - responding to referrals on the basis of the urgency and complexity of the case; - the matching/allocation of referrals and work to the competence of staff and their current workload; - the tracking and reviewing of actions taken in response to the referral;	The hospital procedure reflects cooperating to safeguard children and the regional policy and procedures.

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4.2 Staff have available to them referral, assessment and case planning guidance and criteria to assist them reach professional judgements about recourse to the child protection process which is demonstrable in their practice.	Written guidance on assessment, interviews, case records.	The hospital procedure outlines the referral process and when to refer any concerns.

STANDARD 5
The Board/Trust, in co-operation with other providers and services, has effective arrangements in place for the protection of children in groups known to be vulnerable and in specific circumstances.

Criteria	Indicators/Evidence	
5.1 The ACPC policies state that child protection procedures apply to all settings where children live or meet.	ACPC Procedures.	The hospital complies with this
5.3 Child protection guidance takes account of specific conditions or circumstances: children living away from home; disabled children; risks to the unborn child; children where a parent/carer is misusing drugs/alcohol; child prostitution;	ACPC Procedures	• Disabled children; • Living away from home; • Specific risks posed by other children, young people or adults – the hospital procedure complies with this • The hospital is developing guidelines for staff re: children living in adult environment
5.4 Staff from all disciplines/programmes of care within the Trust and related agencies demonstrate an	Interviews Referrals Case Records Reports	All staff are covered by the hospital procedure and training is given to all.

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understanding and awareness of child protection guidance in their practice.		
5.5 Where there is concern about child abuse actions required are clearly defined.	ACPC Procedures Processes are applied consistently, irrespective of setting; (Judgement) and there are mechanisms in place for providing feedback to the relevant disciplines involved.	Knowledge of procedure is taught at induction supervision and awareness training. Case examples are discussed at ward rounds.
5.6 The Trust treats seriously any complaints or allegations of abuse to a child by a professional, staff member, carer or volunteer/or child and adheres to DHSSPS guidance	Records of Process. Procedures.	The hospital adheres to DHSSPS guidance terms and conditions of services and duty of care and professional standards are all linked to the disciplinary process. Professional bodies code of practice are adhered to.
5.8 There are systems in place for centralising information and collating concerns about children and families arising at different times and in different places.	Records	Incident reports are processed through the hospital management and trust management. Reports on actions are prepared for Governance groups. Individual professions review incident reports at least monthly.

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STANDARD 6
Child protection services respond to the needs of children and their families, operate to high standards, conform to regulations, guidance, policies and procedures and are mentioned and audited by the Board/Trust, ACPC and CPP.

Criteria	Indicators/Evidence	Hospital Action
6.7 The Board/Trust ensures that staff and carers working to safeguard children are supported appropriately through proper induction training and ongoing supervision, and have available to them adequate support services and resources.	Induction programme. Training and Development plans. Service information Supervision records Interviews and focus groups	Children's ward has focus groups, away days. Ward staff have regular meetings. The hospital procedure outlines how to contact the child protection specialist and is available for advice/support as required.

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STANDARD 7
The Boards/Trusts exercise their respective lead responsibilities for the establishment and effective working of ACPCs and CPPs as detailed in Co-operating to Safeguard Children.

Criteria	Indicators/Evidence	Hospital Action
7.1 The ACPC is constituted as required by "Co-operating to Safeguard Children" and has appropriate representation from relevant agencies, at an appropriate level of authority.	Membership/operation	The Trust Child Protection Panel has a nurse and social work representation. A committee is to be set up in the hospital to include the consultant paediatrician and the Child Protection Nurse Specialist.
Trust Child Protection Panel (CPP) 7.13 The Trust CPP membership reflects the range of professionals and agencies involved in safeguarding children in its area.	Term of reference Membership	The hospital issues are an agenda item as required. A recommendation has been made to make hospital issues a standing agenda item. Also see 7.1

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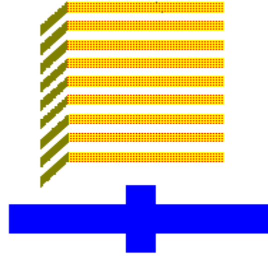

BELFAST CITY HOSPITAL TRUST

Policy and Procedure for the Protection of Vulnerable Adults

Lead Authors: Mr J. Baron-Hall, Mrs E. Hughes
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Responsible Director: Mrs. E. Hayes
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Approved by Chief Executive Mr Q. Coey

Approved by Chairman Mrs J Ruddock

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Policy on the Protection of Vulnerable Adults

Objective
To clarify for all staff of the Trust the steps to be taken in the event of actual or suspected abuse of vulnerable adults.

Policy
The Trust will:-
- Provide training for all staff who may have contact with patients on how to recognise vulnerable adult abuse and the procedures to follow (see appendixes I and II).

- Agree a procedure and guidelines to be followed in the event of a case of suspected or actual abuse.

- Strive to ensure that abuse does not occur within any of the Trust's services.

- Respond appropriately, sensitively and promptly to all cases of suspected or alleged abuse.

- Protect and support individuals where abuse is established.

- Involve all appropriate agencies, egg. Social Services.

Confidentiality
- Information given by an individual about abuse should only be disclosed to those who need it in order to plan or manage any care or treatment that the person may require or where disclosure is required by law or by order of the court.

- Any member of the Trust being informed of or suspecting that abuse has occurred must follow the agreed procedure of the Belfast City Hospital Trust and must ensure that a comprehensive written report is kept for reference.

- Any member of staff suspected of or causing abuse will be dealt with in the first instance through the Trust's Disciplinary Procedures.

- In the event of a member of staff being found to have abused a patient the Trust will notify the relevant professional authority.

Definitions
Vulnerable Adults are those who through illness, frailty or disability are unable to care or protect themselves from abuse and include, the elderly, persons with learning, physical or sensory disabilities or persons suffering from mental illness or dementia.

Abuse
- The physical, psychological, emotional, financial or sexual maltreatment or neglect of a vulnerable adult by another person (see Indicators Appendix 1).
- The failure of appropriate action can also be a form of abuse.

- Wilful maladministration or withholding of medication except for therapeutic reasons.

Consent

If the patient consents to the abuse then action cannot be taken. Their wishes should be respected except where this creates a conflict with a duty to protect others or the law.

For consent to be meaningful it must be given freely and with full understanding.

Before reaching any decision about the ability of the vulnerable adult to give meaningful consent, it is essential that staff consult with their managerial and professional lines and that legal advice is obtained.

Perpetrators

Abuse can occur in a relationship where there is an expectation of trust and by those who have influence over the life of the dependent. These can be formal or informal carers, staff, family members or others.

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DHSSPS (2003): The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003, Belfast)
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DHSSPS (1996): Protection and use of Patient and Client Information, Belfast
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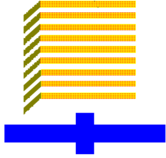
NMC (2004): Code of Professional Conduct, Nursing & Midwifery Council, London
BCHT policies on:- Protection and Use of Patient and Client Information, Patient Consent
DHSS (1993): Access to Health Records (NI) Order, Belfast



Belfast City Hospital Trust

Appendix 1

Protection of Vulnerable Adults

Possible Indicators of Physical Abuse

The following list of indicators is not exhaustive nor should they be taken as proof that abuse has taken place:

- Multiple bruising
- Black Eyes
- Bite Marks
- Burns and fractures not consistent with an explanation given
- Signs of malnutrition
- Signs of force feeding – for example bruising around the mouth
- Inadequate heating
- Wilful misuse of drugs
- Substance misuse
- Misuse of restraint
- Withdrawal of supplied aids
- Delay between the injury and seeking medical attention
- Differing histories or explanations about injuries

Emotional Abuse

- Humiliation
- Harassment, including about financial matters
- Threatening or insulting behaviour
- Enforced social isolation
- Intimidation
- Verbal abuse, including being shouted at or spoken to roughly
- Enforced sensory deprivation.

Sexual Abuse

- Vaginal bruising
- Rectal bruising
- Penile bruising
- Discharge
- Faecal smearing
- Oral bruising or ulceration
- Inappropriate relationships (for example those who suffer from dementia who are distressed by and are unable to be a party to or to understand the relationship).

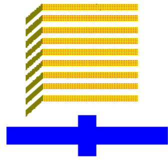
Financial Abuse

- Theft
- Refusing care because of finances
- Blocking access to material goods, including affordable luxuries
- Misuse of property or finances
- Fraud
- Denial of choice or independence of choice.

Social and Emotional Indicators

- The vulnerable person appears withdrawn, agitated or anxious
- Unreasonable isolation in one room of the house
- Inappropriately or improperly dressed
- Unkempt or unwashed – overtly subservient, anxious to please
- Access to a vulnerable person is denied or is restricted unreasonably

Poor Safety standards.



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Appendix II

ABUSE OF VULNERABLE ADULTS INVESTIGATION PROCEDURE FLOW CHART

ABUSE SUSPECTED
↓
Discuss with Line Manager
Seek Advice from Designated Officer

Suspected Abuse by Staff
↓
Discussion by Professionals
↓
Is further investigation necessary?
- Yes → Investigated by Line Management
  - Yes → Trust's Disciplinary Procedure → Refer to other agencies as appropriate
  - No → Trust's Disciplinary Procedure; Note decision on File-close investigation
- No → Note decision on File-close investigation

Suspected Abuse by Other Persons
↓
Formal Referral to Designated Officer
Mrs Christina Doyle ex 3600 or Emergency Duty Team (280) 9056 5444
↓
Discussion/Conference by Professionals
↓
Is further investigation necessary?
- No → Discussion/Consultation Recorded by Designated Officer
- Yes → Designated Officer refers to Investigating Officer,
  Mrs P O'Connor
  Ms S Codd
  Ms C Henry
  ex 3600 for processing

Action taken as appropriate → Refer to other agencies as appropriate