

NSPCC response to Working Together to Safeguard Children consultation

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NSPCC
42 Curtain Rd
London EC2A 3NH
0207 825 2543

Introduction

1. The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC aims to end cruelty to children in the UK over future generations. In pursuit of our vision we will:
 - create and deliver services for children which are innovative, distinctive and demonstrate how to enhance child protection most effectively
 - provide advice and support to ensure that every child is listened to and protected.
 - provide advice and support to adults and professionals concerned about a child and if necessary take action to protect the child
 - work with organisations which work with children to ensure they effectively protect children and challenge those who do not
 - campaign for changes to legislation, policy and practice to ensure they best protect children
 - persuade everyone to take personal responsibility for preventing cruelty to children
 - inform and educate the public to change attitudes and behaviours towards children
 - use our statutory powers as necessary to protect children.
2. The NSPCC provided a response to the pre-consultation exercise for this draft guidance, which closed on 17 December. The consultation document *per se*, to which we respond here, was published on 18 December. It is evident from the text, and unsurprising given the timelines involved, that the draft has not been informed by responses to the earlier exercise.
3. In our earlier comments we expressed a concern that the pre-consultation paper considered only Lord Laming's recommendations; further, it considered a narrower selection of them than we regard as necessary for improving child protection guidance. We remain firmly of this view with respect to the full consultation now being undertaken.
4. We provided in our pre-consultation response a rationale for properly attending to Lord Laming's recommendations 8, 10, 12 and 21.

5. Of those not chosen, the absence of recommendation 12 is the most surprising and concerning:

The Department of Health and the Department for Children, Schools and Families must strengthen current guidance and put in place the systems and training so that staff in Accident and Emergency departments are able to tell if a child has recently presented at any Accident and Emergency department and if a child is the subject of a Child Protection Plan. If there is any cause for concern, staff must act accordingly, contacting other professionals, conducting further medical examinations of the child as appropriate and necessary, and ensuring no child is discharged whilst concerns for their safety or well-being remain.

Guidance to A and E staff on these issues is core to the purpose of Working Together. The government's Action Plan states that the government will work with both the College of Emergency Medicine and the Department of Health Informatics Directorate 'and co-ordinate this work with our broader look at safeguarding training of health professionals and *with the government's revision of Working Together...*' [our emphasis]. This commitment needs to be fulfilled.

6. In drafting this response we have consulted with NSPCC staff providing: services to children, young people and their families, including ChildLine and the NSPCC Helpline; training and consultancy to organisations providing services and the Child Protection in Sport Unit.
7. In responding, we have where possible tried to fit our comments into the framework of the consultation document. It is important to state that a number of those comments are not tied to one chapter but need to be considered across the guidance.
8. We also make some recommendations which are broader than the scope of the *Working Together*, but are important for understanding our comments on the guidance.

General Comments

Focus on the Child

*“This is possibly the single most significant practice failing throughout the majority of the serious case reviews – the failure of all professionals to see the situation from the child’s perspective and experience; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views in supporting their needs.
“(Ofsted 2008)¹*

9. The Biennial Child Death and SCR reviews, the Ofsted evaluations of SCRs and Lord Laming’s report have all commented on failures to focus on the child, let alone engage with them. In the last year the NSPCC has pushed for a legislative amendment that would provide powers for social workers to be able to “see a child alone”.
10. The guidance as currently drafted risks diluting the effect of Lord Laming’s recommendation that all assessments... must include direct contact with the child. In our reading, the proposal is that chapter 5 is revised ‘to include specific reference to the child being seen alone, where appropriate...’ Framed in this way the guidance places the onus on the worker to find cause to see the child alone.
11. **We consider that the guidance should be framed so that there is a clear expectation the child should be seen alone by the lead social worker responsible for the s47 investigation. It may not always be practical to see the child alone, especially if the child is distressed by this. In such cases the reason for not seeing the child alone should be clearly recorded.**
12. The child should be spoken and listened to, and their wishes and feelings ascertained, taken into account (having regard to their age and understanding) and recorded, when making decisions about the provision of services. Some of the worst failures of the system have occurred when professionals have lost sight of the child and concentrated instead on their relationship with the adults. It is essential that child protection work should be child-centred. This important principle is established at paragraph 5.4. However the definition offered in that paragraph is too simplistic. A wider and more helpful definition can be found in the Framework for Assessment of Children in Need and their Families:

This means that the child is seen and kept in focus throughout the assessment and that account is always taken of the child’s perspective. In complex situations where much is happening, attention can be diverted from the child to other issues which the family may be facing..... This can

result in the child becoming lost during assessment and the impact of the family and environmental circumstances on the child not being clearly identified and understood. The significance of seeing and observing the child throughout any assessment cannot be overstated.²

13. There are three elements which need to be set out clearly –

- a) Keeping the child at the forefront; as Ofsted has noted: “Professionals failed to consider the situation from the child’s perspective. Too often they also took the word of parents at face value without considering the effects on the child.”³**
- b) Developing a meaningful relationship with the child (which requires seeing the child), that allows them the space and sense of security to discuss their concerns / worries and fears.**
- c) Ensuring the child’s wishes and feelings are ascertained and taken into account, which again requires practitioners to spend time with the child both alone and with their family.**

14. Some of these elements are present in the guidance. It refers to seeing the child alone “where appropriate”. Further guidance is required, as this is not a simple issue. Our practitioners have commented that:

The guidance is very passive [in saying] “the child must be spoken to/listened to”. It [does] not [take] a child rights perspective. Working Together is treating the child as an object, a passive partner.

15. Children have to feel safe; that they can trust you. They need the space and the time that helps them to talk about difficult and painful things. The guidance does not convey the complexity of this task; as one practitioner said: “*The whole guidance has lost sight of the child*”.

16. The NSPCC aims to work with children and involve them in decision making. We hear from children and young people that sharing information between agencies often deters them from accessing services. In our core standards we state:

As a child protection agency, the NSPCC’s order of priorities with regard to confidentiality and information sharing is:

the welfare of children and young people is paramount;

respect for the principle of appropriate control by service users over the information they provide;

commitment to the concept that child protection is best achieved by a multi-agency approach described in ‘Working Together to

Safeguard Children. (Chapter 3 NSPCC Procedures and Core Standards)⁴

17. We try to offer children and young people a confidential space in which they feel able to openly discuss the problems they are experiencing and to discuss options which leave them feeling that their wishes and feelings have been respected and that they retain some control of events which directly involve them.
18. This practice not unique to the NSPCC, and should be promoted in statutory guidance and practice guidance. There is a need for more detailed advice than that currently available in chapter 5, especially in relation to seeing/ speaking to a child. No guidance has been issued on Clause 53 of the Children Act 2004 (which concerns ascertaining children's wishes). A good starting point for this would be the practice guidance set out in the Assessment Framework for Children in Need.⁵
19. **Work with children needs to be timely, prompt and attentive to their needs. For example the NSPCC sets a time scale for seeing a child from the time a referral is accepted. Setting a time scale for seeing a child may be something that DCSF would want to consider.**
20. There is little mention in the guidance of advocacy. This should be available both to the child and to carers. ChildLine consistently receives calls on this. A recent example relates to a young person who was the subject of a child protection investigation and at the same time had to act as an intermediary to assist their parents, who had learning difficulties. The local authority in that instance was not providing information and the young person had to help the parents understand what was happening. This is clearly inappropriate.

Disability

21. Ofsted in their recent analysis of SCRs⁶ noted that:
 - *disabled children and young carers who may be caring for a disabled parent are not always receiving the assessments of need to which they are entitled and as a consequence do not receive services which meet their needs.*
 - *the focus of support for parents of disabled children needs to be tailored to meet the individual needs of the child and provide the parenting skills to enable the adult to address her or his overall care, safety and well-being.*
 - *good practice in safeguarding children is seen where there are robust links between child protection workers and disability workers and where there is*

sufficient training to increase the understanding and ability of disability workers to take into account both disability and child protection issues.

- *cases involving disabled children benefit from the involvement of more experienced workers with extensive experience when there are dual issues of child protection and complex disabilities involved.*

22. In this context the NSPCC⁷ would make the following points:

- a) The guidance does not integrate issues of disability well across the guidance and all too often the issue of disability appears to be an after-thought. For example, in paragraph 1.22 – 1.32 there is no emphasis on communication when discussing the concept of significant harm and the definitions of abuse (1.28 – 1.32). We know that communication and language lies at the heart of a child’s social, emotional and intellectual development and their overall well-being. If they are denied opportunities to communicate within their family their development and well-being is put at risk. The publication “Deaf Children: Positive Practice Standards in Social Services” produced by the Association of Directors of Social Services, Local Government Association, NCB, BDA, RNID, NSPCC, NDCS in 2000 “states:

“Poor communication between families/carers/siblings and the deaf child could be seen as neglect/emotional abuse, but the worker has to assess the reason for this as well as the implications that this may have for a child’s development. The worker has to consider how much is to do with the information, support and services offered and accessible to families/carers”

Whilst the publication is about deaf children, the issue is of equal relevance in relation to children with a wide range of communication difficulties (for example for those with expressive and receptive difficulties, such as Autistic Spectrum Disorder (ASD) or Auditory Processing Disorder (APD).

- b) It is important to recognise the specificity of some issues, and there needs to be recognition of the differences between disabled children and deaf children. This point is well made in forthcoming research by the University of Manchester commissioned by the National Deaf Children’s Society (NDCS) on the delivery and quality of social care services to deaf children and their families.⁸ The researchers observe that:

The lack of specialist knowledge and expertise [for deaf children] was significant because it demonstrably hampered teams from being able appropriately to recognise the seriousness of a presenting problem when it concerned a deaf child. Within non-specialist service arrangements,

being 'deaf' was rarely seen as encompassing complex developmental concerns or presenting particular safeguarding risks. A situation tended to have to escalate to a generically identifiable crisis before any response was possible. Where teams had specialist knowledge and experience, deaf children and families' needs were significantly more likely to be identified as meeting eligibility criteria for the provision of assessment / services and there were clear referral pathways for families and other professionals alike.

More worrying was the "lack of co-working between child protection teams and specialist social workers, with 18% describing a situation in which there was no co-working at all, either because specialist social workers did not exist to co-work with anyway, or because specialists working in Adult services were not allowed to work cases involving children, or because the CD T [child disability team]-did its own child protection work and did not involve outside deaf-related specialists." In such circumstances, it is clear that specific consideration of deafness is required to ensure the needs of a deaf child are identified and addressed adequately.

- c) **The guidance would benefit from referencing the practice guidance issued by DCSF in 2009.**⁹ This makes several points which require emphasis in guidance. The first is that "*Additional resources and time may need to be allocated, if an investigation of potential or alleged abuse is to be meaningful. This is a basic premise and should not be ignored at any stage of the safeguarding process.*"¹⁰ Thus, while the move to a 10-day period for completing a core assessment is welcomed, difficulties in accessing appropriately skilled interpreters or other specialists may mean that assessments take longer. Where this is the case the reasons should be clearly documented. *Working Together* should also emphasise the point made by Ofsted and reflected in the DCSF practice guidance that "*It is recommended best practice that safeguarding concerns/referrals concerning disabled children are assessed by practitioners who are both experienced and competent in child protection work, with additional input from those professionals who have knowledge and expertise of working with disabled children.*
- d) While reference has made to ensuring interpreters are used, it is important that at both national and local level, guidance is available to practitioners to ensure they understand and are able to resolve some of the issues that arise from using interpreters or other intermediaries in communicating with a child or parent.
- e) As NDCS notes "*language and communication lies at the heart of a child's social, emotional and intellectual development.*" If parents neglect the communication needs of their disabled child they will put at risk the child's social, emotional and intellectual development at risk. This will apply to a

range of disabilities. For deaf children there is concern from members of the Deaf Social Workers group and others about certain behaviours towards children. Examples include parents failing to take care of a child's hearing aid or ensure that it is working (e.g. a failure to renew batteries, missed audiology appointments). Failing to support, or deliberate blocking, a child's ability to communicate, or neglecting a child's means of communication, should be deemed as abusive. Such behaviours should be recognised in *Working Together* under either the emotional abuse or neglect definitions. Social workers need to establish the reasons why carers are behaving in this way and the implications in terms of providing information and support for families to develop the language and communication skills of the child.

23. The forthcoming University of Manchester/NDCS research does set out a very bleak picture for deaf children and it is one that is likely to be true for other disabled children. **It is therefore imperative that *Working Together* sets out clear requirements and expectations that ensure that a deaf or disabled child does receive an equal service and, most importantly, is protected.**

Neglect

24. Current definitions complicate rather than clarify professional decision-making in the area of neglect. Neglect is rarely clear cut, and there have been problems in practice and in the courts. It is worth remembering that the criminal law governing neglect is Section 1 of the Children and Young Persons Act 1933 and that a number of cases fall between the thresholds set by that legislation and those set out in *Working Together*. Gardner found that "*Even when children showed strong evidence of neglect, a parent's action or inaction did not necessarily meet the criminal threshold, while recurring incidents just below the 'significant harm' threshold were often not recorded and considered for their cumulative effect as meriting intervention under the Children Act*".¹¹ An additional factor is the different professional vocabularies used to describe different forms of neglect; for example neglect of the physical, emotional and cognitive needs of the child. Currently there is only one area of parental responsibility where neglect impels clear sanctions and intervention; that is to say, the requirement to ensure a child's educational needs are met. We consider that there is a need to revisit current definitions of neglect within criminal law, family law and guidance, to achieve a better fit that supports, or at least does not hinder, inter-agency work. International comparisons may be helpful (see paragraph 29 below). Ultimately we need to have something that will assist professionals to assess a neglected child and decide how to help them, without allowing them to remain in a damaging situation for too long.

25. Para 1.32 of the guidance as currently formulated defines neglect as:

“The persistent failure to meet a child’s basic physical and/or psychological needs likely to result in serious impairment of the child’s health and development”.

The use of the term “persistent” suggests that neglect has to be long-term and sustained before a care order can be made. Inconsistent care, as in a pattern of recurrent neglect with periods of temporary improvement, is not always taken into account for its cumulative effect on a child. This can result in the courts being unwilling to accept neglect as significant harm without major traumatic incidents or evidence of life-threatening developmental damage over a prolonged period. Thus, action is likely to be too late, with harm having already occurred, and/or severe developmental damage being predicted, even when this was foreseeable due to poor parenting practice.

26. The difficulty is compounded by the wording of *What to do if you’re worried about a child* (DfES 2006), which states that “there are no absolute criteria on which to rely when judging what constitutes significant harm. Some children live in families where their health and development are neglected. For them, it is the *corrosiveness of long-term emotional, physical or sexual abuse [our emphasis]* that causes impairment to the extent of constituting significant harm”. Short of a potentially criminal incident, neglect is not seen to constitute significant harm unless and until it endures over time.
27. As we said in our evidence to Lord Laming, **we strongly recommend that the current definition of neglect used in *Working Together to Safeguard Children* and *What to do if you’re worried about a child* is revised to remove the terms “persistent” and “long term”**. Instead, guidance should be clear that time limits should be built into a child’s care plan to ensure timely assessment of the child’s needs, parental capacity to meet those needs and potential to do so within the child’s time frame. The following wording is proposed in support of this: *“If following the provision of services for a child by agencies for a specified period (on a case by case basis), the child’s health or development is still judged likely to be significantly impaired by remaining within their current care setting it may be appropriate to take action to ensure consistency of care that meets the child’s needs..”*
28. Practice: The NSPCC recommended in its submission of evidence to Lord Laming’s review that the response to neglect needs to be active and pre-emptive. Child neglect is always a sign of serious underlying problems that must be addressed if children are to be safeguarded. A systemic response requires practitioners to be equipped to deal preventively with early signs of child neglect as well as to be ready to step in if a child’s health and welfare are endangered. We note the planned publication by DCSF of:
- Neglect Matters; a multi-agency guide for professionals working together on behalf of teenagers

- Neglect Matters; a guide for young people about neglect
- Training materials currently being developed by the University of Stirling and Action for Children.

29. These are welcome, but further consideration should be given to the need for additional practice guidance on dealing with neglect affecting children of all ages and in a range of circumstances, from neonates to older children, including those who are disabled. Within this there is a need to consider the range and continuum of unmet needs / neglect, providing examples of thresholds for intervention. A helpful model is the Ontario Child Eligibility Spectrum¹² which works through this and sets out the thresholds at which interventions should be considered.
30. Stein, in his review of neglected adolescents, comments that the “*review highlights important differences in the way neglect might be conceptualised at different stages of childhood, but [there is] a relative lack of attention to this within the literature on definitions. There is a risk that definitions may therefore exclude some issues of neglect which are pertinent. This points to the need for the development of more age-sensitive definitions for research and practice purposes.*”¹³ Clearly neglect will manifest itself differently according to a child’s age, ability and circumstances.
31. Decisions and actions need to be made to suit the child’s age and developmental stage (a child’s time frame). Three months of neglect for a newborn has a different impact to that for an 8-year-old and that of a 17-year-old, depending on the individual circumstances, not least because when children are older they, may be more able themselves to take action to ameliorate their circumstances. A month-long wait for a service might be bearable for a 17- year-old, but will feel too long for the 8-year-old. This underlines the point we make at paragraph 28 for clear time limits; such time limits should apply both to case management and legal proceedings.

Structure and format of the guidance

32. The NSPCC agrees with Lord Laming¹⁴ that “*Working Together does [for the most part] set out sound principles and procedures for collaborative working*” but as he goes on to state, these principles need “*to be intelligently and effectively applied in every local service*”, and “*all professionals should explicitly understand their responsibilities.*”
33. There is a perennial debate in all professions about how much professionals should expect to be told what to do and how much should be a matter for professional judgment. The answer will be different depending on where you are on your journey towards professional competence. Our concerns about the structure of the current guidance are its size, focus and clarity of purpose. The guidance has increased from 100 pages in 1999 to 260 pages in 2006 to

300 plus in this current draft (not including chapter 8). The document serves a number of purposes and in our view has become unwieldy in its present structure. Feedback from our staff has highlighted a number of points of confusion:

- How does it sit alongside local procedures?
- Who is it for? The LSCB, a team leader, a police officer?
- Information, especially around specific issues such as disability, is found in a number of different places.
- It is hard to identify responsibilities clearly because of their interweaving with what the organisation/practitioner does.

34. In the light of this **we suggest fundamentally restructuring the guidance into three separate documents which are cross-referenced with one another:**

- a) **Responsibilities - A heavily edited chapter 2 that states clearly the responsibilities of each agency.**
- b) **Responding to a specific incident / concern - effectively Chapter 5: the process of identification, assessment, intervention and support**
- c) **The role of LSCBs – this would include chapters 3 (LSCBs), 4 (training), 7 (Child Death Overview Panels) and 8 (Serious Case Reviews).**

The other chapters have value and should be made available but seen as support to practice.

35. Such a restructuring would make it easier to signpost different organisations and their staff to the information they *must* know and to information that can *support* them in safeguarding a child.

36. To avoid people losing sight of the wider picture it will be also important to be able to cross-reference and flag issues / areas that they need to be aware of depending on their role. **We therefore recommend that the guidance be developed as an online resource, with the use of tagging (setting out key words) which would enable an online user to pull out sections of relevance to them.** This would be analogous to a service already provided by train companies: it is possible to log on to the www.nationalrail.co.uk¹⁵ website, enter your requirements, and be provided with a bespoke pocket timetable to download. In this context, someone working in a voluntary organisation would be able to answer a series of questions and be sent a PDF file setting out their role, contacts and relevant procedures. Alternatively, someone with a specific query, such as assessing an unaccompanied asylum-seeking child, would be sent the relevant practice guidance.

Role of the voluntary sector

37. The voluntary and community sector is a major and often majority provider of non-statutory services to children in any given area. In Hackney for example there are over 2000 services to children provided by community groups. The third sector merits greater emphasis and attention than that given at the fifth bullet point of this paragraph, where it simply says:

'The LSCB should seek to coordinate the effectiveness, and scrutinise the activity to safeguard and promote the welfare of children, of all those agencies within the LSCB area who have statutory responsibilities to safeguard and promote the welfare of children or who have non-statutory roles to play in this respect. The latter group is likely to include parents and carers, voluntary and community sector groups, individual youth organisations and faith groups.'

38. We are aware through our services, our Child Protection in Sport Unit and our Helplines of the frustrations that can arise when a referral is made to children's social care. Our staff flag up significant concerns but sometimes struggle to secure action by local authorities. We propose that LSCBs be required to review how referrals are handled in their area, and how partners can be challenged to improve their practice if this is necessary.

39. We propose that NSDU considers whether a mechanism can be identified to aid improvement, such as an independent appeal mechanism.

DCSF Consultation Questions

1 a) Does chapter 2 sufficiently capture the wide range of partners who share responsibility for safeguarding and promoting the welfare of children? Please give any suggested additions.

Yes

No

Not sure

Comments:

There are two groups which require further attention: the community and voluntary sector and the sports and leisure sector.

Chapter 2 makes very limited reference to the third sector, given the enormous scope and diversity of the sector and its potential for identifying and safeguarding children within the community. Much more coverage is given to the faith sector (including a list of contacts that will quickly date and which arguably does not belong in a guidance document). We would like to see more reference to the contribution made by organisations within the children and young people's sector, such as sports, arts and leisure groups and also community groups (including BME groups) that involve children but do not have them as their main focus.

Feedback from colleagues in the sports sector has identified concerns about how they are overlooked although they are one of the biggest providers of services to children and young people. The landscape of sports is complex; currently the national sports governing bodies, Sport England, DCMS, the Child Protection in Sport Unit (CPSU) and the NSPCC are developing a plan to set out "the roles for all organisations safeguarding children and young people in and through sport". This needs to be reflected / signposted in the document.

Further reference is also required in chapter 3 to how LSCBs should be engaging with sports bodies including how they might be represented on the LSCB. LSCB links with such bodies tend to vary greatly. There are gaps in safeguarding where the LSCB could provide a useful role as they have an overview of how organisations can work together.

We also propose amending the elements relating to the NSPCC in paragraphs 2.203 - 2.206 as follows:

The current draft states:

2.203 The NSPCC is one voluntary organisation that provides a number of relevant services. It operates ChildLine which provides a telephone helpline across the UK for all children and young people who need advice about abuse, bullying, and other concerns. It also operates a national helpline to enable anyone who is concerned about the welfare of

a child or young person to have someone to turn to.

The NSPCC would like this to be amended as follows:

Voluntary organisations play a key role in providing information and resources to the wider public about the needs of children and young people, and resources to help families. Many campaign on specific issues on behalf of groups.

The NSPCC is authorised to initiate proceedings to protect children under the auspices of the Children Act 1989 and offers a number of services to children, adults and practitioners. It operates a 24/7 UK-wide Helpline service (0808 800 5000) advising adults and professionals on safeguarding matters and where necessary liaising with local statutory agencies to refer children at risk of abuse. The NSPCC also operates ChildLine (0800 1111) which provides a telephone helpline across the UK for all children and young people who need advice about abuse, bullying, and other concerns.

These helpline services, through their accessibility, via telephone and online, and through providing anonymity and confidentiality, enable users who may be reluctant to speak out to seek advice when they need to and enable others to alert the authorities to children at risk where this is necessary.

In conjunction with other bodies it also provides child protection advice; for example the Child Protection in Sport Unit (CPSU), established in partnership with Sport England, provides advice and assistance on developing codes of practice and child protection procedures to sporting organisations. The Safe Network, jointly managed by the NSPCC and Children England, provides advice for the third sector and is working to create safeguarding standards for voluntary/non-profit sector organisations.

Safeguarding advice, information and update bulletins are also disseminated through the NSPCC's online and email services for professionals: www.nspcc.org.uk/inform.

1 b) Are their roles and responsibilities sufficiently clear? Please give any suggested additions.

Yes

x No

Not sure

Comments:

Chapter 2 draws together roles and responsibilities and in doing so extends to 215 paragraphs. This makes it difficult to focus on what should be expected of an organisation. For this reason we have proposed that there be a specific document which sets out responsibilities for each agency (see paragraph 34 above).

Health Professionals

It should be explicitly stated that designated healthcare professionals (HCPs), whether located in commissioner or provider arms, *should not* also act as the named professional. This is particularly relevant where designated HCPs are additionally contracted to provide clinical or nursing services, where it is likely that there will be conflict with their duty to "... review and evaluate the practice and learning from all involved health professionals and providers ..." (para 2.118)

Paragraphs 2.77-2.82 should include the following: Service commissioners should develop local performance indicators to provide assurance that safeguarding awareness, practice and appropriate procedures, including use of the Common Assessment Framework, are embedded in provider services.

If feasible, we would like paragraph 2.96 to be specific about how frequently health visitors should have child protection supervision. We suggest the following wording: "Health visitors should receive quarterly child protection supervision, provided by an appropriately qualified child protection professional to ensure good practice".

Paragraph 2.45 should be amended to include the following: "All health professionals who work with children, young people and their families, parents or carers, including adult services and independent sector providers should" etc.

Paragraph 2.85 should be clarified as follows: "GPs have a role in appropriate information sharing (subject to normal confidentiality requirements, and in line with the cross-government guidance *Information Sharing: Guidance for practitioners and managers* and associated training materials....." etc.

2.17 Another group that should be included is children whose parents are in the armed forces and are either deployed or at risk of being deployed.

2.109 We agree that CAMHS teams should have a role in providing treatment,

but this is not something that always happens. Our study on the availability of therapeutic services found “*that there had been a lack of priority given to child sexual abuse in CAMHS.*”¹⁶

2.119 It needs to be clearer whether named professionals on LSCBs are attending only as a named professional or also as a representative of their employer.

Pg 54: The guidance does not address the interface between schools and vulnerable adults. It is not clear for example what guidance would be used to respond to a 17-year-old with learning disabilities who is at a college and is being abused. The guidance needs to state clearly that *Working Together* is the appropriate statutory guidance to use under-18s

2.184 There is no mention of private nurseries.

2.208: Under faith communities, the guidance also needs to recognise the communities’ involvement in supporting “dangerous adults”, such as Circles of Support groups. In such circumstances it is important for groups to have clear policies and protocols for safeguarding children.

2 Does chapter 3 clearly set out the LSCB’s responsibilities to improve the outcomes of children? Please give any suggested additions.

Yes

x No

Not sure

Comments:

This chapter is confusing from the onset when at 3.6 it locates with the local authority and its partners the responsibility to ensure any extended role does not lessen the LSCB’s ability to perform its core role effectively, rather than locating this with the LSCB itself. It is contradictory when at 3.23 the guidance suggests that LSCBs will also wish to evaluate the quality of...training and in the next chapter, at 4.14, it is required that Boards should review and evaluate the provision and availability of single and inter-agency training to ensure training reaches all relevant staff.

It falls short of delineating the workforce adequately when at 3.25 no reference is made to volunteers. **Procedures exemplified at 3.28 as pertinent to asylum-seeking children, traveller children, children in migrant families and children of families in temporary accommodation should be additionally inclusive of children resident in the secure estate outwith their home authority.**

At 3.36, the responsibility placed on LSCBs to monitor action subsequent to injuries sustained by young people restrained in a custodial setting should be accompanied by some exploration of any power residing in the LSCB to challenge the action taken.

Paragraph 3.84 requires the local authority to secure the involvement of other local organisations. In our view, this should be the responsibility of the LSCB. Securing adequate arrangements for representation of such a diverse sector is always challenging. The guidance should emphasise that the LSCB should satisfy itself that the voluntary sector representative(s) understand that they are attending in this capacity and not solely representing their own agency. Where there is a representative of a national organisation such as the NSPCC there should in addition be a representative of the local community and voluntary sector.

LSCBs should be expected to provide training and induction to members who are unfamiliar with safeguarding and the processes that support it.

Some specific comments

Pg 65: flowchart - under the effectiveness of work, there needs to be another box which covers challenge and how dissent is handled.

Para 3.29: The language is passive and should be more active; we propose amending the text to: LSCBs must consider the need for other local protocols under this function, beyond those specifically set out in regulations, including: ... etc.

Para 3.55: In this and other sections it would be helpful to be clearer about defining independence. Does 'independence' mean being independent from the organisation, the team or the case?

Para 3.67: Whilst it is important that members of LSCBs have strategic authority, they also require an appropriate skill set. Recommendations have been made about ensuring in local authorities that training is made available to Directors of Children's Services (DCSs) and others who have no experience in safeguarding. We consider this should apply to all members of an LSCB board.

Pg 87: There is no clear reporting mechanism for the community, voluntary or faith sectors.

3 Is the guidance clear enough on the responsibilities of LSCBs and partner agencies in relation to agreeing local thresholds for making referrals to children's social care services? Please give suggestions on how it could be clearer.

Yes

No

Not sure

General comments:

Lord Laming said in para 3.11 of his Progress report that: "*Thresholds are an attempt to limit access to services either because of finance or staffing constraints. Thresholds have no statutory basis and are not part of the Framework for the Assessment of Children in Need and their Families.*

The variation in thresholds for providing services for children in need and children at risk vary considerably. While this may be understandable, it is not acceptable; the guidance does nothing to address Lord Laming's concerns in this regard.

It is important that government, possibly through the National Safeguarding Delivery Unit or other appropriate agency, should actively consider the extent to which local thresholds can be standardised. The criteria for these thresholds must be transparent.

We recognise that this cannot be achieved in the current timescales for revising the *Working Together* guidance but urge the government to make it a priority.

Specific comments:

In our reading, this responsibility appears only to be referenced as a sub-clause in paragraph 3.18 when delineating the policies and procedures function of the LSCB as '*including thresholds for intervention*'; as a suggestion at 3.19, that responsive work to protect children '*may mean...setting out thresholds for referrals...*'; and as a hope at 3.21, that '*clear thresholds...may ensure that appropriate referrals are made*'.

The guidance is not clear what should happen when someone has concerns about the safety and wellbeing of a child who is not at risk of significant harm. This is not resolved in the interface between the CAF and initial assessments (sometimes referred to as a child in need assessment). This does not assist in setting thresholds. Ofsted in their review of SCRs noted that there was *Inadequate recognition as Children in Need: "Six of the 19 serious case reviews included disabled children whose needs had not been assessed under the Children Act 1989. Where services were needed, these were not therefore provided for the children. The reviews found that inexperienced staff were allocated to these cases but, because they were not defined as 'children at risk', they were given a lower priority".*¹⁷

Thresholds are to an extent understandable when it comes to provision of services, but do not seem tenable at the point of assessment. Lord Laming made this point clearly in his review, but this is something that the guidance does not adequately address.

To improve the situation at a local level:

- All staff must be clear about the purpose and use of CAF.
- All organisations need to have some agreed and common criteria for referrals.
- Some mechanism to monitor referrals and to highlight concerns at either an LSCB or Children's Trust level.

Another gap relating to thresholds is the gap in providing services. In our recent mapping study of therapeutic services, our researchers found that many of the referral routes to therapeutic services have to come through social care (e.g. being a child in need or subject to a child protection plan) which means there are many children who receive no service because they have no plan.

4 Is the relationship between the LSCB and Children Trust Board clear? Please give any suggested additions.

Yes

No

Not sure

Comments:

However, the guidance would benefit from an elaboration of the role of the LSCB and the Children's Trust. We are aware of inconsistencies in this role across the 70 Boards attended by NSPCC representatives and have no reason to assume there is greater consistency across the remainder. It might be useful to describe this role as being a 'participating observer'.

In addition, we note that guidance on the role and functions on the LSCB of the Director of Children's Services and the Lead Member is plentiful and detailed. **It would be helpful to develop reciprocal guidance on the LSCB's role within the Trust.**

This suggested guidance would sit well after paragraph 3.64. It would also be useful here to reference the role of the local authority's Chief Executive in ensuring the effectiveness of the relationship between the LSCB and the Children's Trust (currently at 3.72).

We propose that paragraph 3.67 should be amended to include: "Members should be people with a strategic role in relation to safeguarding They should have sufficient authority to:

- **Speak for their organisation with authority;**

- **Commit their organisation with respect to policy, practice and adequate funding or resourcing in kind for safeguarding and child protection purposes; and**
- **Hold their organisation to account.**

5 Are the expectations regarding the LSCB annual report clear? Please give any suggested additions.

Yes

No

Not sure

Comments:

In addition, **it would be helpful if the concept of ‘robust challenge’ could be enlarged upon, as we would hazard it unlikely that there is a consistent understanding of this requirement.**

The Government Office of London has produced a narrative template on this issue which is helpful.

6 Are the expectations regarding the appointment of lay members to the LSCB clear? Please give any suggested additions.

Yes

No

Not sure

Comments:

The guidance needs to expand on what is meant by ‘representation’, ‘public engagement’ and ‘responsibility’.

We do not understand why at paragraph 3.81 it falls to the local authority rather than the LSCB to determine the expectations of the lay member. It is assumed this is an error in drafting; if not it requires explanation.

Paragraph 3.79 states that lay members should provide a link between the LSCB and local community groups. It is not clear how they can be expected to fulfil this role and there is a risk of confusion between this role and that of the voluntary sector representative(s). We suggest that this requirement is removed and that the lay members’ contribution is to provide a lay voice only, rather than linking with other groups.

The following questions relate to chapter 4.

7 a) Are the respective roles and responsibilities of employers, Children's Trusts and LSCBs in respect of staff training set out clearly enough? Please give suggestions about what else might assist in providing clarity.

Yes

x No

Not sure

Comments:

We have two points of concern:

1) There is potential for confusion over the responsibility for training and whether this rests with the Trusts or LSCBs. This needs clarification. However, we are aware of emerging practice where LSCB trainers and Children's Trust trainers work closely together on integrated training strategies which include safeguarding. We believe this is positive and would want this to be encouraged.

2) The voluntary sector, especially smaller community-based groups, are dependent on the multi-agency training provided by LSCBs to develop awareness of safeguarding and child protection among their staff and volunteers. Currently, many LSCBs have excellent models for the delivery of this training and over many years have developed structures for its planning and delivery.

We are concerned that the potential confusion between the responsibilities of the Children's Trust and the LSCB may have a negative impact on ensuring effective child protection training. Guidance should require these issues to be addressed at a local level.

Pg 91: A missing element under LSCB is the provision of induction to LSCB members.

Para 4.27: It would be helpful to name volunteers explicitly in this list.

Para .4.42: Is this a set of minimum standards and is there an expectation that LSCBs will monitor the supervision arrangements?

7 b) Would it be helpful to have more detail which sets out the generic elements of effective supervision for all types of practitioners? Please give suggestions about what these generic elements should be.

Yes

No

Not sure

Comments:

The guidance is very agency-specific in focusing on social care. 'Supervision' is understood differently in other contexts, such as education. **The guidance would benefit from being expanded to incorporate the different models of scrutiny and support operating in different agencies.**

Some agencies have no model of supervision and should be encouraged to develop a model for child protection work.

The following questions relate to chapter 5.

8 Is the focus on understanding what the child's daily life experiences and wishes and feelings are when undertaking an assessment of a child in need and intervening, including where they are suspected to be suffering significant harm, strong enough? Please give suggestions on how it could be strengthened.

Yes

No

Not sure

Comments:

This section needs to be strengthened significantly. The government has identified the *Working Together* guidance as the key mechanism for ensuring that practitioners have a more effective focus on the child.

We have commented extensively on these issues above (paragraphs 9-20), as our comments do not apply solely to this question, but relate also to other elements of the guidance.

The guidance within the Assessment Framework for Children in need would be a good starting point for setting out guidance in relation to this and Section 53 of the Children Act 2004.

9 Is the guidance on when to make a referral to children's social care services clear? Please give suggestions about how it could be improved.

Yes

No

Not sure

Comments:

The Common Assessment Framework (CAF): References are made to the use of the CAF in paragraphs 1.21, 5.15 and 5.32. The statements are confused and at odds with the guidance set out for practitioners and managers by the Children's Workforce Development Council (CWDC) which states that the CAF is not appropriate for situations where there is a concern that a child or young person may be suffering, or be at risk of suffering, significant harm.

There are also gaps between a CAF and referral to children's social care. This cannot necessarily be resolved by guidance, but could be managed at local levels by middle managers discussing cases which are referred and not accepted and ensuring that learning from this is fed back to practitioners.

We propose that the text of paragraph 1.25, on the impact of abuse described as forming the basis for Section 47 investigations, should supplement the current definitions of significant harm. This would address issues that come up in SCRs. The onus would be on making good quality referrals, which are well evidenced, and show the impact on the child.

10 Do you agree with the proposal in Chapter 5 at 5.37 that an initial assessment, where one is undertaken, should be completed within a maximum of ten working days of the date of referral (this is a suggested change from the previous 7 day timeframe)? Please give further comments.

Yes

No

Not sure

Comments:

The move from 7 days to 10 days for completing an initial assessment is welcome, but it needs to be acknowledged that there will be circumstances in which this is not possible e.g. when a child is in trauma, or a child requires specific communication support (either due to disability or not having English as their first language) .

11 For looked after children, who are also the subject of a child protection plan, do you agree that the child protection plan should form part of the looked after child's overarching care plan? Please give suggestions about how this proposal might be taken forward in practice.

Yes

No

Not sure

Comments:

We would suggest that the DCSF consider the work of the Scottish Government and their local partners on the Getting it Right for Child agenda, and specifically the work in the Highlands on developing a single plan and single meetings to encompass child protection plans and other issues. Initial findings suggest that the move to a single plan and set of meetings is beneficial for the child and effective in ensuring a holistic and joined up approach.

Other comments on chapter 5

Throughout, and particularly in Chapter 5, the document refers to professionals. It does not define what is meant by the term but there is an implicit assumption that they are those employed within the statutory sector. It should be made explicit that the term is inclusive of people working in third sector organisations. A common concern within the community and voluntary sectors is that they sometimes receive no response, or an inadequate one, when they refer concerns about a child to children's services. *Working Together* should clearly state that a referral from a third sector organisation should be given the same status and response as one from a statutory agency. At the same time, it should recognise that community and voluntary organisations cannot be expected to carry the same degree of responsibility for children at risk of significant harm as statutory organisations.

5.4 , 5.89: Whilst the NSPCC acknowledges that the focus needs to be on the individual child, there is little in the chapter which considers issues for siblings. As part of any investigation consideration will need to be given to the needs of other siblings who may not have experienced the abuse but will nevertheless be affected by it.

5.35: Information from our Helplines shows that it can be hard to obtain feedback after making a referral. In situations where no action is taken it would be helpful wherever possible for the reasons for that decision to be provided.

5.36: If a case is open to children's social care, there should as a minimum be an initial assessment; thus it would be more appropriate for the initial assessment to be updated, or a core assessment undertaken.

5.114: We have concerns that on occasion the core group fails to meet. We

therefore recommend that there is a clear requirement that meetings should take place.

5.136: Chairs of case conferences and reviews should be independent.

This question relates to chapter 6.

12 This chapter provides references to other guidance which is supplementary to Working Together in respect of particular groups of potentially vulnerable children and categories of abuse. Do you have any comments on this chapter?

Yes

No

Not sure

Comments:

The issues of additional vulnerability are important but are currently scattered across three chapters: 6, 9 and 11. These need to be drawn together in a format that:

- a) Identifies the research evidence for why there are additional vulnerabilities;
- b) sets out best practice; and
- c) identifies further sources of information / advice.

It may be more effective to use one website as a portal for the various websites such as Research in Practice, SCIE, the NHS e-library and NSPCC Inform where people can easily access information and research. This would be easier to access and keep updated.

6.16: We propose that the final sentence be amended to: “Midwives and doctors may become aware that FGM has been practised on an older women and this should at a minimum lead to female children being checked”.

13 The paragraphs on the roles and responsibilities of the CDOP now occur before those on the rapid response team. Does the revised structure of the chapter work? Please give any other suggestions for the order of these paragraphs.

Yes

No

Not sure

Comments:

14 Will the revised definition of preventability assist CDOPs in making decisions on whether a child's death was preventable? Please give any other suggestions for the definition.

Yes

No

Not sure

Comments:

We propose that the guidance includes a specific reference to abuse and neglect as modifiable factors. We suggest the text of paragraph 7.22 is revised as follows and have highlighted for ease of reference where we consider this reference could be included – we are not proposing that it should be emphasised in italics in the final text:

“For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors, *which include abuse and neglect*, are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

15 Is the definition of 'unexpected ' child deaths clear? Please give any other suggestions for the definition.

Yes

No

Not sure

Comments:

While we welcome the comments on children with disabilities, chronically ill children and those with life-limiting conditions in paragraph 7.6, there is no mention of disability in the paragraphs (7.20 and 7.21) on 'unexpected' child deaths.

We are aware of concerns expressed by those working with disabled children that when they die unexpectedly their deaths are not always viewed as unexpected. We strongly agree with Ofsted that: "good practice in safeguarding children is seen where there are robust links between child protection workers and disability workers".¹⁸

We recommend therefore that paragraph 7.20, bullet point 1 should be revised to read:

"which was not anticipated as a significant possibility i.e. 24 hours before the death, including the deaths of children who are disabled, chronically ill or those with a life-limiting or life-threatening condition".

16 Are the expectations regarding the involvement of parents in the process clear? Please give any suggested additions.

Yes

No

Not Sure

Comments:

The additional guidance in paragraphs 7.7-7.12 concerning the involvement of parents/family members in all child deaths is a welcome addition.

We also have further comments on chapter 7:

7.15: We welcome the requirements for Registrars to provide information about deaths.

7.23: The NSPCC also welcomes the extension to consider "... modifiable factors ... in the family and environment, parenting capacity or service provision ..."

7.25: Population size. We are aware that in certain areas with smaller

populations, there are greater staffing and time costs involved in operating Child Death Overview Panels (CDOPs), and learning is reduced because less information is yielded. We consider the guidance would be stronger if CDOPs were required to cover a minimum population of 500,000 and adjoining administrative areas were required to make appropriate arrangements to achieve this. This would assist with identifying trends and themes and with promoting action to help prevent child deaths.

7.38 Refers to professionals retrieving "... relevant case records"; we consider this should refer to retrieving ALL case records. Appropriate security should be in place to ensure accurate transfer.

The following question relates to chapter 9.

17 Have you any suggestions about additional research findings that should be referred to in this chapter? Please give your suggestions with references.

Yes

No

Not Sure

Comments:

We have made recommendations above about restructuring the guidance (see paragraphs 32-36) and also about the range of places that information is held.

Research is rarely static; rather than updating references, we would recommend a web page to direct people to helpful sites such as Research In Practice. This will make it easier for information to be kept fresh and up to date.

The following question relates to chapter 10.

18 Are there other aspects of working with children and their families that you think ought to be covered in this chapter? Please give any suggested additions.

Yes

No

Not Sure

Comments:

1. It is essential that child protection work should be child-centred. This important principle is established at paragraph 5.4. However the definition offered in that paragraph is simplistic and focuses primarily on seeing the child. A wider and more helpful definition can be found in the Framework for Assessment of Children in Need and their Families:

This means that the child is seen and kept in focus throughout the assessment and that account is always taken of the child's perspective. In complex situations where much is happening, attention can be diverted from the child to other issues which the family may be facing..... This can result in the child becoming lost during assessment and the impact of the family and environmental circumstances on the child not being clearly identified and understood. The significance of seeing and observing the child throughout any assessment cannot be overstated.¹⁹

There are three elements which need to be set out clearly –

- a) Keeping the child at the forefront; as Ofsted has noted: "Professionals failed to consider the situation from the child's perspective. Too often they also took the word of parents at face value without considering the effects on the child."^{20[2]}
- b) Developing a meaningful relationship with a child, which allows them the space and sense of security to discuss their concerns / worries and fears.
- c) Ensuring their wishes and feelings are ascertained and taken into account.

2) The guidance needs to be clearer and stronger on the issues of parents with learning disabilities and parents with mental health problems.

The sub-heading preceding paragraph 2.110 conflates two groups of adults coping with very different challenges under the term 'adult mental health services'. Whilst the responsibilities of staff providing services would be the same, there is a likelihood that someone in an adult learning disability team may not see this as being relevant to them. We would suggest that either this is made explicit or that the guidance should include a distinct section on learning disability. We would prefer the latter.

There is a need to ensure appropriate assessments are made of parents with learning disabilities. Ofsted commented in their report on SCRs that “*Where the reviews identified a disabled parent, there were also issues concerning the impact on the whole family. In four of the eight cases there was a failure specifically to assess the parenting skills of parents with learning disabilities.*”²¹ The need to ensure assessment of the effects on the whole family should be reinforced in guidance. A failure to do so can at worst lead to an increased chance of serious harm and at best lead to further delay to securing a child’s safety and promoting their well-being.

The interface between adults’ and children’s services need to be better addressed; this is a point made frequently in child death inquiries and reviews. A cultural shift is required to ensure that the duty of care is towards the child as well as the adult service user. This guidance can support that by strengthening the language and setting out clear expectations about involvement, and participation at strategic and operational levels. The National Service Framework for Children, Young People and Maternity Services sets clear standards for such joint working, and could be usefully referenced here.

For example paragraph 3.75 should be amended to say “*The local authority must ensure that those responsible for adult social services functions are represented on the LSCB.*” Our representatives on LSCBs have also commented that whilst there may be a representative of adult services on the LSCB this does not necessarily lead to a better interface at a practice level, with children’s services. In this respect, while it is not for guidance, adult services will need to consider how they improve two-way communications between those who are on the LSCB and practitioners, and how those responsible for strategic management of adult services should set out clear expectations of their teams that they will work alongside children’s services in safeguarding children.

The NSPCC recommends an amendment to the statement in paragraph 2.112 to “*This will require sharing information...*” rather than “*this may require sharing information.*” Such a change sets out a clear message about expectations.

The following question relates to chapter 11.

19 Are there other groups of potentially vulnerable children or categories of abuse which you think should be mentioned in this chapter specifically? Please give any suggested additions.

Yes

No

Not Sure

Comments: These points are made in this section but should be read in conjunction with our points made about the structure of the guidance.

Hence if the structure is to be retained as it is, there should be good cross-referencing between the chapters.

Child trafficking

1) **We recommend that each LSCB should undertake a review of the range and scope of their child protection procedures, assessing whether they reach and meet the needs of young people aged 16 to 18 who may have been trafficked.** This should also include an assessment of the education and training facilities of young people in this age group, who may not have received a traditional education through usual formal routes and who may have emotional and mental health needs.

2) **'A keyworker approach should be adopted for safeguarding trafficked children and young people.** This should be developed in consideration of the recommendations of Lord Laming's report *The protection of children in England: a progress report* (TSO, 2009) for reflective practice and for practice with complex cases to be undertaken (or closely supervised) by a social work consultant within safeguarding teams. The keyworker approach notes that disclosure is more likely to take place once the child or young person has developed a trusting and supportive relationship with a keyworker.

3) **'At the point of entry into the UK, a social work keyworker, trained in safeguarding children and young people, should be allocated to each child or young person.** An independent guardian should also be employed, but this should not negate the need for the LSCB to allocate a social work keyworker to oversee the management of the child's case from the outset.'²²

Unborn children

The draft document has very little to say about unborn children. Para 5.14 states that child protection procedures and time scales should be the same as for other children. Feedback from our staff suggests that additional practice guidance would be helpful to promote consistency of practice in this area. Such issues focus on the role of GPs and midwifery services in identification of child

protection concerns, protocols for organising pre-birth case conferences and the time scales involved.

The following questions relate to chapter 12.

20 a) Are there other arrangements for managing individuals who pose a risk of harm to children which you think ought to be mentioned in this chapter? Please give any suggested additions.

Yes

No

Not Sure

Comments:

Overall this chapter is too adult-focused; it would be helpful to separate it into two distinct sections - one relating to adults and one relating to under-18s and those under 10. These are all instances where there is least likely to be clarity about how to proceed.

It may also be helpful to include details about the planned roll out of the child sex offender review disclosure pilots.

20 b) Do you have any comments on the arrangements described in this chapter (e.g. MAPPA, MARAC)? Please give your comments.

Yes
 No
 Not Sure

Comments:

We find this very clear, and supportive of the crucial role of the IDVA. We note that at paragraph 12.30 MAPPA takes precedence over MARAC as the former is statutory; and ask only whether this warrants review once the latter is placed on a similar statutory base.

Name: Vijay Patel / Lucy Thorpe
 Organisation (if applicable): NSPCC
 Address: 42 Curtain Rd
 London
 EC2A 3NH

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| <input type="checkbox"/> Local authority childrens service | <input type="checkbox"/> LSCB | <input type="checkbox"/> Other local authority service |
| <input type="checkbox"/> SHA | <input type="checkbox"/> PCT | <input type="checkbox"/> Health sector(other) |
| <input type="checkbox"/> Police | <input type="checkbox"/> Probation board | <input type="checkbox"/> Youth Offending Team |
| <input type="checkbox"/> Parent/Carer | <input type="checkbox"/> Young person under the age of 19 | <input checked="" type="checkbox"/> Third sector |
| <input type="checkbox"/> Private sector | <input type="checkbox"/> Schools sector | <input type="checkbox"/> Early years sector |

¹ Ofsted Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008 December 2008

² DH Framework for the Assessment of Children in Need and their Families 2000

³ Ofsted Learning lessons from serious case reviews: year 2 Oct 2009

⁴ http://www.nspcc.org.uk/Inform/resourcesforprofessionals/PSPs/PSPs_wda48961.html

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- ⁵ DH Framework for the Assessment of Children in Need HMSO 1999
- ⁶ Ofsted (2009) Learning lessons from serious case reviews: year 2
- ⁷ As a member of the National Working Group on Child Protection and Disability, we know these concerns are also shared by other members.
- ⁸ Young *et al* The impact of integrated Children's Services on the scope, delivery and quality of social care services for deaf children and their families. University of Manchester/NDCS forthcoming
- ⁹ DCSF Practice Guidance – disabled children July 2009
- ¹⁰ DCSF Practice Guidance – disabled children July 2009
- ¹¹ Gardner R, (2008) Developing an effective response to neglect and emotional harm to children, – UEA/NSPCC (unpublished).
- ¹² <http://www.oacas.org/pubs/oacas/eligibility/index.htm>
- ¹³ Stein, M *et al* (2009) Neglected adolescents – literature review. DCSF.
- ¹⁴ Lord Laming (2009) The Protection of Children in England: A Progress Report
- ¹⁵ <http://ojp.nationalrail.co.uk/en/p/home/show>
- ¹⁶ Allnock, D *et al* (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need NSPCC.
- ¹⁷ Ofsted (2009) Learning lessons from serious case reviews: year 2.
- ¹⁸ Ofsted (2009) Learning lessons from serious case reviews: year 2.
- ¹⁹ DH (2000) Framework for the Assessment of Children in Need and their Families
- ²⁰ Ofsted (2009) Learning lessons from serious case reviews: year 2
- ²¹ Ofsted (2009) Learning lessons from serious case reviews: year 2
- ²² Pearce, J.J., Hynes, P. and Bovarnick, S. (2009) Executive summary of Breaking the wall of silence NSPCC and University of Bedfordshire.