

4. CHILDREN LIVING AT HOME

INTRODUCTION

4.1. The majority of children live at home. This chapter focuses on children receiving universal services and children in need, including those in need of protection, children with disabilities and children on care orders who have been placed at home. It also considers children placed for adoption. Children encounter a wide range of agencies: schools, the NHS, and sometimes social services and the police. Also, agencies are increasingly commissioning services from the private and voluntary sectors as well as providing them directly.

4.2. This chapter looks at how well agencies safeguard children living at home, and, where possible, how children themselves feel about it. Some of the findings apply to children in all settings, not just those living at home. Evidence comes from mainstream inspections of social services, schools and other education settings and health services and from a recent thematic inspection of the investigation and prevention of child abuse by Her Majesty's Inspectorate of Constabulary [ref. 7 <http://www.homeoffice.gov.uk/hmic/stayingsafe.pdf>]. This chapter does not cover in detail the experiences of children and young people in the private and voluntary health sector, although safeguarding arrangements are an important feature of the regulation and inspection work the Healthcare Commission has carried out in that sector since April 2004. Detailed findings are included in the Healthcare Commission's published reports.

4.3. Special attention is given in this chapter to children with disabilities living at home, in line with the recommendation from the first *Safeguarding Children* report. Children with disabilities are especially vulnerable and research evidence suggests they are much more likely to suffer abuse and neglect than other children [refs. 8 <http://www.nspcc.org.uk/inform/NWGCPD/ItDoesntHappenToDisabledChildren.asp>, and 9 <http://www.anncrafttrust.org/publications.html#finalreport>]. Welfare concerns sometimes go unnoticed because of the difficulties of identifying the signs of abuse or of communicating with some children, or because of reluctance by practitioners to suspect abuse.

4.4. There are varying definitions of disability in use. Alongside children with disabilities, we have considered other children with additional needs in this report in view of their increased vulnerability. This includes children with statements of special educational needs for emotional, behavioural and social difficulties as well as those with learning or physical disabilities. This chapter includes evidence about children with disabilities from social services and education inspections and from a special review of 10 special schools and 17 resource centres for pupils with special educational needs in mainstream schools.

LISTENING TO CHILDREN'S VIEWS

4.5. The importance of communicating and consulting with children and young people and listening to their views cannot be over-estimated. The *Victoria Climbié Inquiry Report* found that the consistent failure to communicate with Victoria was partly responsible for concealing her situation [ref. 10

<http://www.rights4me.org.uk/whatyoutoldus/childrens+views+on+health/default.htm>

and http://www.csci.org.uk/publications/childrens_rights_director_reports/default.htm].

Children themselves have firm views on the subject:

'Treat us individually rather than as children as a whole.' [ref. 11

http://www.csci.org.uk/publications/childrens_rights_director_reports/childrens_views_green_paper_every_child_matters.pdf]

*'Listen to children like they matter and so you believe it.'*¹

'Talk to us, not through our parents.' [ref. 13

<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en>]

4.6. There has been overall improvement since the first *Safeguarding Children* report. Agencies give more priority to recognising children's rights and views and to communicating with them and their parents. For example, some councils have developed special websites for children and provide dedicated advocacy services. Other councils are using innovative approaches with software programmes that help young people express their views in a child friendly way, as are some youth offending teams. In health settings, there is an increasing focus on listening to children to ensure that their needs are met and environments are suitable. Examples include children's or young people's groups, young people's websites and 'talking walls'² where children can express their views. However, some agencies give such initiatives higher priority than others. Also, the views of many children with disabilities are not heard because insufficient effort is put into overcoming the communication, sensory and/or learning barriers.

Good practice

Newcastle Hospitals NHS Trust actively seeks the views of children and young people, for example through their Children's Voices Project, and includes young representatives on the Patient Public Forum.

[Healthcare Commission/CSCI]³

¹ *Children's Views about Health Services*, Pat Doorbar Associates, 1995.

² A wall surface on which children can write or attach notes raising issues of importance to them.

³ Names of inspectorates which have provided evidence for good practice boxes through the report

'This year when school council makes decisions it is acted upon. We have a good say in what goes on.' (Secondary school pupil with hearing impairment).

'I did not understand the words they were using...Nobody explained anything to me about going home...People told me different information and confused me.' [Ref. 15
<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en>]

4.7. Survey results⁴ suggest that children generally have positive working relationships with social workers and feel they are listened to. Out of 613 children, 48% (296) said they could always speak to their social worker and 29% (178) said they could usually do so. Similarly, in the majority of special education establishments, pupils feel safe. They feel staff take seriously what they say and know who to go to if they have concerns. However, the effort that agencies devote to seeking children's views is variable and often depends on the continuity of staff, which is undermined in services with a high staff turnover.

'[It's helpful] having a social worker who listens to my views...knowing I will be listened to...the social worker listening and helping me talk with my daddy.' [ref. 14 http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf]

'I know who to talk to if I have a problem.' (Hearing-impaired child in a primary school)

'There is always someone to talk to – it may be a favourite teacher but the learning mentors are always there for you.' (Secondary school pupil with a hearing impairment)

4.8. The provision of child-friendly complaints systems still varies. This is reflected in survey results⁵ about social services' complaints systems: 66% (401) of children who responded knew how to make a complaint, but 26% (161) did not. Some acute hospitals do not have complaints leaflets specifically aimed at children and young people. There is also evidence that direct access by children and young people to Patient Advice and Liaison Service (PALS) advocates is inconsistent. NHS staff sometimes act as advocates for children but this could lead to conflicts of interest. Many independent hospitals that treat small numbers of children do not have child-friendly complaints systems.

INVOLVING AND INFORMING CHILDREN AND YOUNG PEOPLE

⁴ Social Services Inspectorate (Commission for Social Care Inspection from 1st April 2004) questionnaire surveys of children over 8 years of age, 2003-04.

⁵ Social Services Inspectorate questionnaire surveys of children over 8 years of age, 2003-04.

4.9. Work by social services to help children to protect themselves, for example against substance misuse, self-harming or domestic violence, is mainly focused on older children and young people. There are examples of targeted work with families with adolescents at risk of family breakdown helping to reduce the numbers of looked after children. This work is in place in some councils but not in others. In special education establishments and mainstream schools, personal, social and health education (PSHE) covers issues such as bullying, self-harming, drug awareness, sex education and personal safety. This area of the curriculum is an essential part of preparing children and young people to protect themselves from harm and abuse and is especially important for vulnerable children with disabilities. Even when PSHE is well taught, there is not always enough emphasis on harm from people known to children.

Good practice

Innes School in Rochdale is an all age school for pupils with severe, profound and multiple learning difficulties. The school's PSHE programme includes relevant modules about keeping safe, using schemes of work and supporting materials specifically designed for pupils with learning disabilities. For example, specific lessons focus on giving pupils the knowledge and confidence to speak or communicate to a range of adults if they have worries.

[Ofsted/CSCI]

4.10. The provision of information about services to children and parents presents a variable picture. For example, where social services have a good range of information, it is in languages and formats suitable for children who access the service, including websites. Where information is less satisfactory, common factors are that it is out of date, inadequate or incomplete and not targeted to children. Some Local Education Authorities (LEAs) have made good progress in using web sites and information leaflets to provide more comprehensive information about services and support for pupils and parents.

Good practice

At Dudley College of Technology, there is a wide range of help for personal, financial, domestic, childcare, transport and health problems that prevent students from staying in education. Child protection measures have been in place for over six years. Student diaries given at induction clearly outline the protection all students, including those over 18, can expect.

[Ofsted]

4.11. Agencies recognise that they should pay attention to a child's ethnic, cultural, religious and language needs. In practice, they are still not taken sufficiently into account across all settings. Councils usually have a range of policies and generally try to take account of diversity issues. However, only one third of councils believe that they consistently communicate effectively with children whose preferred language is not English or who use non-verbal forms of communication [Ref. 52

<http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspector>

4.12. Police forces are now paying close attention to diversity across most areas of activity. However, diversity is not as clearly or as well integrated into child protection policies and procedures as those relating to adult victims of crime. Specialist interpreters who are skilled at working specifically with children are rarely available. Most NHS trusts have access to some form of interpreting service. In practice, however, there can be difficulties or delays in locating specific interpreters, for example for children who require interpretation to be in an alternative medium such as sign language. Also, expertise in communicating with children with disabilities is still inadequate, so that those with general and specific communication difficulties are disadvantaged.

4.13. Some services do not keep children and parents sufficiently informed about and involved in matters of concern to them. In some social services departments, parents are not always clear about what needs to happen for their child's name to be removed from the child protection register⁶. In addition, for children placed for adoption, there is not always sufficient emphasis given to the child's perspective. Health services have improved significantly in explaining treatments and care plans for children. Most special education establishments give good feedback to parents or carers about their child's educational progress but they provide little information specifically about safeguards or child protection procedures.

MAKING SAFEGUARDING A PRIORITY

4.14. All agencies that have direct involvement with children need to see the safeguarding and welfare of children as one of their major priorities. This is reinforced by the Children Act 2004, which places a specific duty on them to ensure that they take account of the need to safeguard and promote the welfare of children in their work [ref.3 <http://www.dfes.gov.uk/publications/childrenactreport/-2004>]. The children's National Service Framework has also helped to raise awareness in both the NHS and the independent health sector. Across agencies, there is evidence of significant improvement in the priority given to safeguarding since 2002. Policies and procedures are more child-centred and there is a greater acknowledgement at senior levels of the need to promote safeguarding.

4.15. Mainstream state schools have improved considerably since 2000 in complying with the statutory responsibility for child protection of pupils in schools, although this is more variable in the secondary sector than in the primary sector. Many schools have effective policies for reducing oppressive behaviour. This corresponds with those schools that have a high incidence of free school meals (an indicator of higher deprivation). 91% (72) of LEAs

⁶ A central register maintained by each social services department, listing all the children resident in the area who are considered to be at continuing risk of significant harm and for whom there is a child protection plan.

inspected have policies for health and safety and child protection that are satisfactory or better. Nonetheless, these policies and procedures are not consistently adapted to take account of the needs of children and young people with communication, sensory or learning disabilities.

4.16. Nearly all NHS trusts now have a person with responsibility for child protection at board level. Most trusts also have named and designated health professionals in post. This has significantly raised the profile and status of child protection issues. Some types of trust show considerable improvement. For example, in 2003, only 60% (18) of ambulance trusts had a board level child protection lead, whereas in 2004 all ambulance trusts had one. However, not all NHS boards receive an annual report on child protection. For example, 82% (141) of acute trusts and 90% (272) of primary care trusts receive such a report, but only 53% (16) of ambulance trusts do [refs. 15, 16]. Independent health providers have also improved in the extent to which they have developed these recommended safeguarding features, following increased focus on this area by inspectors.

Good practice

South London and Maudsley NHS Trust, which specialises in mental health services, has significantly raised the profile of safeguarding. Initiatives include: a board level lead and dedicated child protection staff; a comprehensive audit of the implementation of recommendations from serious case reviews; a CAMHS risk management committee, which considers complaints, serious incidents and serious case review recommendations; and mandatory child protection training programmes. An audit of pregnant women and those with young children using mental health services was a joint initiative with Southwark social services and considered safeguarding issues, reflecting a key ACPC priority.

[Healthcare Commission/CSCI]

4.17. All but one of the 43 police forces have clear child protection procedures and guidance. However, child protection is not a priority in 41% (18) of policing plans, mainly because there is a lack of focus on children's safeguards at a national level. Child protection is not a national priority area or currently monitored by means of a national performance indicator.

4.18. The safeguarding needs of some specific groups of children and young people are not given sufficient priority. For example:

- The provision of services for young people aged 16-18 is often inconsistent and there is often a gap between children's and adults' services. This is especially so for young people with chronic illness or disability and in Child and Adolescent Mental Health Services (CAMHS), although the Department of Health Public Service Agreement requires that, by December 2006, all PCTs should commission a comprehensive CAMH service for children up to their 18th birthday. To address the gap in provision, many paediatric specialists continue to see young people over 18 in some NHS trusts,

particularly where there is no adult specialist for a particular condition. Also, some trusts have set up joint clinics with adult services and have protocols on how to address transition services;

- Continuing capacity problems in both NHS and independent sector CAMHS services often result in children being cared for in adult wards. A survey during 1999-2001 found that almost two thirds of young people under 18 needing in-patient psychiatric care were admitted to adult wards. The Mental Health Act Commission have regularly voiced their concerns about the treatment of children within adult mental health services [ref.59 <http://www.mhac.org.uk/>]. Children in such environments have limited access to advocacy, education or age-appropriate activities;
- There is sometimes a failure to recognise child protection concerns for children placed for adoption;
- Our inspection evidence shows that some councils have placed children on care orders at home with their parents without following regulations⁷ or sufficiently monitoring them. Returning children to parents could sometimes be seen as a way of reducing out-of-area placements, rather than ensuring the needs of the children are paramount;
- Secondary and special schools are less compliant with safeguards requirements than primary schools and nursery schools. Also, in special schools, policies such as those for preventing bullying are not always adapted to the specific needs of children with disabilities; and
- Safeguards for children with disabilities are not always given a high priority in all social services, although there is now a greater acknowledgement of child protection issues than in the past. There are, however, some examples of good practice in catering specifically for the needs of children with disabilities.

Good practice

In Norfolk County Council, three specialist teams across the county provide services for children with disabilities covering the full range of functions, including child protection and support to looked after children. There is a high level of joint working across agencies with individual children and multi-disciplinary assessments. The independent organisation Triangle has run courses on direct communication and child protection with children with disabilities, reaching around 100 staff.

[CSCI]

ASSURING SAFEGUARDING IN PRACTICE

⁷ The Placement of Children with Parents Regulations, 1991.

4.19. Safeguarding policies need to be supported by robust arrangements for audit and monitoring and systems for feeding back the learning into service improvement for children. This remains an area for development in all services.

Particular concerns arise across agencies about whether policies and procedures for safeguarding are put into practice or apply uniformly throughout organisations. For example, the NHS audits carried out in 2003 show that the vast majority of NHS organisations have child protection procedures, but there were some doubts in these audits about whether they were put into practice throughout the organisation. Some NHS organisations were also concerned that areas outside dedicated children's areas are not child-friendly or that not all staff respond fully to individual children's non-medical needs [ref. 15 http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf]. Inspections in the independent sector have found a similar situation.

4.20. In social services, auditing of practice now happens more often but presents a mixed picture. For example, most councils are able to evaluate how extensively black and minority ethnic communities take up services, but councils are at different stages of development in adapting their services and systems in response [Ref.52

http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4076335&chk=sYTWwQ

]. In police forces, limited auditing takes place within child protection and there is an over-reliance on supervision to ensure that standards are met. Management information collected is primarily quantitative and gives little indication of the performance of Child Abuse Investigation Units, nor is it always being used to inform improvement. In the NHS, audits in 2003 found that monitoring of compliance with standards was inconsistent. Monitoring of independent contractors⁸ by primary care trusts was particularly variable, but in 2004 only 62% (188) of primary care trusts were monitoring the implementation of child protection arrangements in GP practices [ref. 16 <http://www.healthcarecommission.org.uk/InformationForServiceProviders/PerformanceRatings/fs/en>].

Good practice

The Vale Resource Base, Haringey, is an all age school for pupils with physical disabilities. The designated teacher for child protection regularly reviews and monitors the records kept. A designated subcommittee of the governing body, monitors policies and procedures relating to safeguarding and ensures that they are accessible to pupils.

[Ofsted/CSCI]

RECOGNISING AND ACTING ON WELFARE CONCERNS

4.21. Ensuring welfare concerns are promptly identified and acted upon is fundamental to safeguarding. Awareness of potential welfare concerns has improved both within and between agencies. For example, frontline police

⁸ Including general practitioners (GPs), dentists, optometrists and pharmacists.

officers outside child abuse investigation units are aware of the need to identify and report child protection concerns when attending incidents such as those involving domestic violence. There is also evidence that the use of the *Framework for the Assessment of Children in Need and their Families* [ref. 17 <http://www.archive.official-documents.co.uk/document/doh/facn/fw-00.htm>] is improving and that good inter-agency working has contributed to improvement.

4.22. Other evidence shows that there is a mixed picture. Numbers of children on the child protection register remained almost static during 2002-04, but this masks wide variations between councils. Where there has been a reduction in numbers, this may reflect increased levels of trust between social services, education, health and youth justice services as well as better engagement from parents. However, this could also reflect some social services' views on how to demonstrate improved performance. Allied to concerns, considered below, about how referral thresholds are being applied, there is a risk that some children in need⁹ could be falling through the safeguarding net.

4.23. Most concerning of all, evidence from a wide range of sources indicates that there are continuing problems in two key areas: recognising or acting on welfare concerns; and inappropriately high referral thresholds in many social services departments. It is of concern that these were also findings from the first *Safeguarding Children* report and the post-Victoria Climbié Inquiry audits [refs. 15 http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf, 18 http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspector/Letters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4004257&chk=gQ%2BFkE]. It means some children continue to be at risk and are not receiving an adequate response to their needs. These issues are considered in detail below.

4.24. First, not all agencies ensure that staff know how to recognise the signs of abuse or neglect and how to act on them. Furthermore, it is not always easy for staff to gain access to relevant information or advice about welfare concerns to inform decisions about what action to take. This has serious implications for certain groups of children. Pre-school children are a particularly vulnerable group. Overall, providers are unsatisfactory in less than 1% of childcare inspections. However 3% of those inspected during 2003/04 (nearly 28,000) had difficulty in demonstrating that they can meet the required standard of knowledge for recognising and reporting child protection concerns. Most of the 542 childminders who failed to meet this standard did so because they were unsure how to report concerns. The 279 day care providers who failed to meet the standard usually did not have effective procedures for staff to follow when they needed to report concerns. In some NHS trusts, identifying welfare concern is compounded by difficulties in accessing previous case notes or the child protection register, and by some poor record keeping and auditing. Many trusts are now undertaking audits of

⁹ As defined under section 17 of the Children Act 1989.

records and access to the child protection register has improved since 2003, but it is still not comprehensive.

Good practice

At St Mary's, part of Central Manchester and Manchester Children's University Hospital NHS Trust, if a midwife identifies child protection issues or other concerns, they are discussed with the family, the line manager and, if necessary, another midwife. These discussions are documented on a special form, which includes an action plan and is filed in the notes. A copy is sent to the named midwife, who keeps it in a central file. If a referral is made to another organisation, an agency referral form is completed and filed in the mother's notes and its contents discussed with the family.

[Healthcare Commission/CSCI]

4.25. Recognising child protection issues for children with disabilities raises particular concerns. In some areas, these children are under-represented on the child protection register. This may be because any marks or injuries are not always recognised as possible abuse, practitioners may be reluctant to suspect abuse, or because of communication difficulties between a practitioner and a child. Special schools generally make child protection referrals appropriately. However, staff are not always good at identifying and tracking behaviour patterns and trends, whether the behaviour shows itself as overt challenge or emotional withdrawal. These can be indicators of child protection concerns.

Good practice

At Sweyne Park, a secondary school for pupils with hearing impairment, staff are routinely expected to monitor and record pupils' attitudes, learning and behaviour. Any welfare concerns arising are recorded on incident forms, which are regularly checked by heads of year with the designated teacher for child protection.

[Ofsted]

4.26. Between 2002 and 2005, there were few serious case reviews¹⁰ of children with disabilities reported. However, there is evidence that the recording and notification of incidents and serious case reviews are inconsistent and there is uncertainty about the precise numbers of serious case reviews carried out. This is compounded by confusion in some NHS trusts about when it is necessary to hold a serious case review or when an internal management review of a critical incident is appropriate.

4.27. Social services report that agencies do not always understand thresholds for referrals, sometimes delay making referrals and are unclear to

¹⁰ A review carried out under Chapter 8 of *Working together to safeguard children* [ref. 22]. When a child dies or suffers a serious injury, and abuse or neglect are suspected to be a factor, the Area Child Protection Committee is required to carry out a review of the involvement of agencies and professionals.

whom they should refer. Referrals are still not always followed up in writing, despite the recommendation of the Victoria Climbié Inquiry, and the requirement to do so in the widely distributed document '*What to do if you're worried a child is being abused*' [Ref 61

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010283&hk=YpgIw9]. Similarly, police forces indicate that there are delays in social services and NHS staff notifying them of concerns that may affect criminal investigations. There is little evidence of joint auditing between the police and social services to ensure that referrals are made appropriately and promptly.

Good practice

Bolton Metropolitan Borough Council developed the Bolton Child Concern Model, which set out graduated levels of vulnerability on a continuum of child concern. The model helped all agencies working with children to achieve a shared understanding about the thresholds for intervention. It also enabled children and families to access services without the need for unnecessary referral to child protection services. The model was later adapted to work within the Identification, Referral and Tracking (subsequently Information Sharing and Assessment) model, for which Bolton was a trailblazer council.

[CSCI]

4.28. Secondly, many agencies report that thresholds for referrals are too high in some social services departments, which are prioritising child protection but not responding appropriately to all children in need. Agencies also report that the response from social services is sometimes slow and there is a lack of feedback about outcomes. This view reflects a complicated picture. Social services may be dealing with priorities as far as resources allow, rather than meeting specific levels of need. Staff shortages and workload pressures also combine to raise thresholds in practice. Also, there are sometimes unrealistic expectations by other agencies of the role and responsibilities of social services.

4.29. Since many council social services are unable to respond sufficiently to families needing support, other agencies do not always refer children when concerns about their welfare first emerge. Some families are therefore likely to be subject to avoidable pressure and children may experience preventable abuse or neglect. Relationships between social services and other agencies are also placed under considerable pressure. The *Every Child Matters* agenda has been developed partly to address these concerns. In particular, the Common Assessment Framework is being developed to support earlier assessment and intervention from a range of agencies, so that only appropriate referrals are made to social services [ref. 55

<http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1310>].

Some councils are already working effectively with partner agencies to enable children and families to access services without the need for unnecessary referrals to child protection services. However, given the current pressures in the system, local councils and their partners will need to review their capacity to deliver and to overcome the long-standing concerns about inappropriately

high social services thresholds.

4.30 As the local change programme develops and local children's trusts are established, care will need to be taken to clarify accountability arrangements and responsibility for forward planning between the Local Safeguarding Children's Boards and the children's trust governance arrangements. Particular attention will need to be given to ensuring that thresholds for specialist services are consistent with ensuring that children are safeguarded effectively. Children and Young People's Plans, which must be in place for April 2006, will need to reflect priorities for safeguarding as well as for universal and preventive services.

4.31 Special schools report particular concerns about children and families in need of support and indicate there is a better response from social services to child protection enquiries¹¹. They also express concerns about social workers' understanding of disabilities and special educational needs. This sometimes applies to social workers in specialist teams for children with disabilities. Inspections also raise concerns that social services are not sufficiently identifying child protection or welfare issues for children placed for adoption. There also appears to be more complacency in dealing with allegations about prospective and approved adopters and some examples where concerns have not been followed up sufficiently.

Good practice

In Richmond-upon-Thames, the Disabled Children's Team is developing its role to ensure that children are safeguarded and protected. Initiatives include: a protocol with the Initial Response Team about joint visits to new referrals where responsibility is not yet clear; specialist training, including training in abuse materials to assist communication with children with disabilities; specialised counselling for children with disabilities; and vetting, training and support for staff, carers and volunteers.

[CSCI]

WORKING TOGETHER TO SAFEGUARD CHILDREN AND YOUNG PEOPLE

4.32 All the evidence indicates that children are safeguarded best where there is clarity and understanding between different agencies about roles and responsibilities, underpinned by good working relationships at all levels. There are examples of good joint working, for example between police child abuse investigation units and children's teams in social services and between social services and health, especially where there are on-site social workers in hospitals. This is one of the good practice markers in the children's National Service Framework. Some trusts have regular multi-agency team meetings involving social workers to ensure that concerns and care plans about a child are appropriately shared. Also, schools for pupils with disabilities report examples of good joint agency training and the benefits of

¹¹ Under section 47 of the Children Act 1989.

shared understanding of roles and responsibilities across agencies.

4.33 However, good multi-agency working sometimes depends on personalities in the absence of robust protocols and procedures and it is not uniformly satisfactory. For example, there is sometimes a lack of clarity between the police and social services about the status of investigations and the criteria for deciding whether an investigation will be single or joint. Similarly, the police role in strategy discussions and case review conferences is not always well defined. Comprehensive new guidance from the Association of Chief Police Officers (ACPO) on child abuse investigations will clarify the role of the police [ref. 19 <http://www.acpo.police.uk/asp/policies/Data/Child%20Abuse%20-%20ACPO%20guidelines.pdf>].

Good practice

In Durham Constabulary, a formal meeting takes place between the Vulnerability Unit Sergeant and social services team manager a few days after the strategy discussion. The aim is to identify whether all the actions agreed at the previous meeting have been carried out and to consider any further action necessary to progress the investigation. The results of the meeting are formally recorded and a copy is kept on the case file.

[HMIC]

4.34 Other findings include:

- There is a lack of clarity between agencies about what information can be shared or a reluctance to share it. Cross-government guidance for practitioners on appropriate and lawful sharing of information is being produced;
- Child protection core groups are not always working well. Their purpose is not always appreciated by agencies other than social services, resulting in poor attendance and delay in agreeing the Child Protection Plan and the necessary steps to improve the family situation; and
- There are very variable relationships and poor communication between schools and social services compounded by LEAs and social services departments failing to devise strategies to address poor working relationships. This should be addressed within the *Every Child Matters* agenda, and in the development of integrated children's services, with a specific responsibility on senior managers to ensure that there are effective working relationships within and between agencies.

Good practice

Leeds Teaching Hospitals NHS Trust has clear information sharing protocols with the police and social services. Social workers can access and write notes on medical records.

[Healthcare Commission/CSCI]

4.35 At a strategic level, Area Child Protection Committees (ACPCs) currently exist to bring together in a council area the agencies and professionals responsible for helping to protect children from abuse and neglect. They will be superseded in 2006 by Local Safeguarding Children Boards (LSCBs), statutory bodies whose detailed role and remit will be subject to consultation in 2005. Inspection findings raise a number of issues for consideration in the development of LSCBs.

4.36 The effectiveness of ACPCs has improved since the first *Safeguarding Children* report and much effort has been put into revising and updating ACPC procedures. However, there is still considerable variation in the extent to which they provide active and effective leadership. This is affected by representation that is not always at the right level, lack of involvement or representation of some important groups (GPs are particularly difficult to engage) and inconsistent attendance.

4.37 There is also evidence that serious case reviews do not always fulfil their function. They are intended to bring together the results of management reviews carried out by individual agencies to identify and share the lessons from cases about working together. However, there is confusion in some agencies about the definition and recording of serious case reviews (see paragraph 4.26), frequent delays in completing them and reports that recommendations are not always sufficiently specific or realistic. Furthermore, the lessons do not always reach all relevant professionals, especially front-line staff, and concurrent criminal proceedings can delay feedback. Several councils have run multi-agency workshops on lessons to be learned from Serious Case Reviews and have provided related training, such as working with hostile families.

ENSURING SAFE ADULTS WORK WITH CHILDREN AND YOUNG PEOPLE

Recruitment

4.38 Some services are under considerable pressure because of difficulties in recruiting and retaining suitably qualified and experienced staff, especially in social services in London and the south east. The resulting high workloads for individual managers and staff contribute to delays in responding to referrals and allocating cases and to tensions between agencies, often to the detriment of individual children. Councils are adopting a range of strategies for improving recruitment and retention, but some of them will take time to work through in practice. They include:

- offering a rolling programme of trainee schemes, which combine work with access to accredited courses as part of a 'home-grown' approach. This route into social work has proved very popular;
- identifying competencies required for the range of tasks to be delivered, and creating differentiated posts requiring skills or qualifications other than those traditional to social work;
- establishing partnerships for recruitment with other organisations, such as health services;
- recruiting staff from outside the UK;
- establishing structured career pathways for people entering the social care profession;
- offering a competitive salary structure and other financial benefits such as loyalty payments. However, this approach to remuneration needs to be cautiously applied to avoid inflating the market and increasing staff instability;
- responding to staff concerns to improve staff retention. This has led to a range of approaches, including: providing access to a range of accredited post-qualification courses; giving financial recognition for increased expertise; ensuring staff are well-supported in carrying out their work; encouraging staff to contribute to improving services; and offering flexible, family-friendly, working patterns and benefits;
- encouraging agency staff to apply for permanent posts by offering the range of benefits described above; and
- adopting a creative approach to recruitment, including: attractive marketing campaigns giving the council a distinctive identity; rolling recruitment through the council web-site; and a continuous focus on maintaining high levels of staff in post.

4.39 The Children's Workforce Strategy will take forward these initiatives, among others, such as the development of a single qualifications framework for the children's workforce, and development of local workforce strategies, as part of an overarching strategy to deliver the objectives of the *Every Child Matters* agenda [Ref.55 <http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1310>].

4.40 The status of work in the area of child protection has improved in some services. HMIC's review of child protection in 1999 found that staff working in specialist child protection teams in police forces felt undervalued [ref.20 <http://www.homeoffice.gov.uk/hmic/childpro.htm>]. Since then, there has been a significant change in understanding and perception of the role of Child Abuse Investigation Units among police officers. The requirement for unit staff to undertake the Initial Crime Investigators Development Programme is specifically highlighted as having had a positive impact on perceptions. This

has contributed to a greater understanding of child protection issues throughout forces and a growing awareness of child protection as a frontline policing issue.

Safeguarding checks on staff

4.41 Following the Soham murders, Sir Michael Bichard's Inquiry made a range of recommendations on information management and sharing, and staff vetting [ref.21 <http://www.dfes.gov.uk/childrenandfamilies/bichardimplementation/pdfs/bichardreport.pdf>]. At the time of this review, the government was consulting on a proposed centralised vetting and barring scheme for people working with children and vulnerable adults [ref.57 <http://www.dfes.gov.uk/consultations/conDocument.cfm?consultationId=1317>]. This would extend the scope of existing compulsory checks to a wider range of employees and volunteers. It would also assist the detection of people already working with children and vulnerable adults who become unsuitable, so that they can be prevented from continuing in this work. The proposals, if accompanied by more rigorous and quality-assured recruitment processes introduced by employers, would strengthen the system and address some of the concerns raised in this report.

4.42 However, it will take some time to implement fully the Bichard recommendations in relation to staff vetting. In the interim, recruitment practices continue to raise considerable concerns. Arrangements are generally in place throughout services to check the background of all staff recruited on a permanent basis. However, there are some concerning variations, especially in respect of staff who move to a different job with the same organisation, staff in post for many years who have not been rechecked (especially in residential schools) and temporary staff and voluntary workers. Some services, notably the NHS, also report continuing difficulties in the timely processing of checks by the Criminal Records Bureau (CRB). These are recurring themes throughout this report.

4.43 In social services, policies and procedures on recruitment and vetting generally exist. Despite this, there is inconsistent checking of staff in unsupervised contact with children. For example, two separate references for new employees are not always on file and qualifications are not always checked. Common problems include no evidence of CRB checks, gaps in employment history and no evidence of qualifications. A central record of agency staff is not always kept, or references verified, so that unsatisfactory agency staff can move from one council to another.

4.44 In the mainstream state schools inspected, the overall position in relation to staff checking is satisfactory. However, in independent schools, 24% (23) of the 96 schools inspected did not comply with appropriate staff checks and this is a serious cause for concern. In special education establishments, checking of staff is done for permanent staff but is less rigorous for contractors. For the seven LEAs judged unsatisfactory, a common feature was inconsistency of enhanced CRB checks on adults in

contact with children.

4.45 In NHS organisations, audits in 2003 found that CRB checks were carried out for permanent staff, but rechecking was inconsistent [ref. 15 http://www.dfes.gov.uk/acpc/pdfs/Audit-findings_report_web.pdf]. The checking of temporary staff and volunteers was not always done as a matter of course. Not all NHS organisations had a specific person with responsibility for ensuring that checks are made with the CRB, although in 2004 all types of NHS organisations had improved in this area [ref. 16 <http://www.healthcarecommission.org.uk/InformationForServiceProviders/PerformanceRatings/fs/en>]. Some trusts are now rechecking staff when they move within the organisation.

4.46 There is also concern about the vetting of the increasing numbers of staff coming from outside the UK to work in public services, particularly in the NHS. The CRB is unable to perform checks outside UK jurisdiction and staff have to be checked on any information that has been brought to the attention of the professional associations or prospective employers by employees themselves. This issue was the subject of a recommendation by the Bichard inquiry. Although there are a number of initiatives in progress to improve cross-border co-operation, this matter requires urgent attention.

4.47 In police forces, all staff are subject to vetting on appointment but further checking on appointment to Child Abuse Investigation Units is not routinely carried out. However, new ACPO guidance on child abuse investigations addresses this by stating that staff working in these units should be subject to a particularly high level of vetting and that this process should be described in any advertisements for posts [ref. 19 <http://www.acpo.police.uk/asp/policies/Data/Child%20Abuse%20-%20ACPO%20guidelines.pdf>].

Training and skills

4.48 Agencies acknowledge that regular supervision of staff is highly important in safeguarding children, but its frequency and quality vary. This is often affected by high workloads carried by first-line managers. For example, not all NHS trusts have named doctors and nurses and many do not currently provide protected time to carry out the role. In providing data for the child protection performance indicator in 2004, a number of trusts said they were addressing the issue of protected time. Several also commented that guidance about the roles and functions of named and designated staff is not clear and needs updating.

4.49 ACPCs provide basic awareness training in child protection that complements induction training provided by individual services. Well co-ordinated cross-agency training is also an important feature of effective safeguarding arrangements. LEAs and social services departments jointly organise and run training on child protection for designated teachers and for school governors. From September 2003 to March 2005, of the 45 LEAs inspected, 89% (40) were judged satisfactory or better for training in child

protection and health and safety.

4.50 There are also some good examples of specialist training. Many NHS trusts have set up models for three levels of safeguarding training. Level one, normally mandatory, is an introduction to safeguarding children to all staff. Level two is more detailed and extensive and includes, for example, recognising signs and symptoms, referral procedures and roles and responsibilities of different agencies. Level three includes children with disabilities, annual updates, learning from serious case reviews and specialist subjects such as forensic medical examination. Most programmes have been favourably evaluated.

4.51 However, there are some common shortcomings in training provision, which include:

- lack of training in safeguards issues for staff outside specialist teams in social services, for example: in adoption teams; disabled children's teams; and teams working with adults with learning difficulties or mental health problems;
- staff in a range of settings not consistently trained in child protection and safeguarding to meet the needs of children with disabilities;
- gaps in specialist training for Child Abuse Investigators in police forces (to be addressed by ACPO-commissioned training) and for designated teachers in some schools;
- poor staff participation in both child protection and behaviour management training in schools where compliance with child protection is less satisfactory. There is also low participation by GPs in training provided by primary care trusts. This was a finding in the first *Safeguarding Children* report, although there has been some improvement since 2002;
- variable training in special education establishments for staff other than designated staff, although staff generally receive written guidance about issues such as physical contact; and
- under-provision of up to date training for council staff on race, cultural and equalities issues. Many council staff say they lack confidence in working with families from different backgrounds [ref.52 http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ChiefInspectorLetters/ChiefInspectorLettersArticle/fs/en?CONTENT_ID=4076335&chk=sYTWwQ].

CONCLUSIONS

4.52 There has been considerable progress since 2002 in the extent to which agencies give priority to safeguarding children who live at home. This is illustrated by greater effort devoted to listening to and consulting with

children, increased commitment at senior levels to safeguarding and more extensive inclusion of safeguarding in policies and procedures. Many agencies are now working together better, assisted by greater clarity about respective roles and responsibilities, and have put effort into improving working relationships. Also, there are many skilled and committed staff working with children and young people.

4.53 However, children are not uniformly receiving the care and protection they need and there are a number of key areas for improvement. Some of the issues will be addressed through the development of the *Every Child Matters* agenda, and agencies need to continue to build on the good work carried out since 2002. Areas for improvement include:

- monitoring how extensively the safeguarding ethos spreads throughout organisations;
- giving priority to the safeguarding needs of children with disabilities; children aged 16-18 with a mental health condition or a chronic illness; and children placed for adoption;
- giving greater consideration to the complexity of working with children with language and communication difficulties;
- clarifying for staff how to recognise and report the signs of abuse or neglect;
- clarifying thresholds in social services to ensure that all children in need receive an adequate response;
- improving relationships and communication between some agencies, for example between education and social services and NHS trusts and social services, especially where social services thresholds are perceived to be high. These need to be jointly addressed by the agencies concerned through the *Every Child Matters: Change for Children* agenda;
- addressing the variation in the membership and effectiveness of ACPCs in consulting on and establishing Local Safeguarding Children Boards; and
- ensuring consistent recruitment and checking procedures for new and existing staff and contractors who are in contact with children.