Background

**Working Together to Safeguard Children**

In March 2015 the Government revised the statutory guidance ‘Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children’.

This guidance was originally published in response to recommendations from Professor Eileen Munro’s report: *A Child-Centred System (June 2010)* that clarified the core legal requirements placed on individuals and organisations to keep children safe.

The Working Together guidance sets out, in one place, the legal requirements that health services, social workers, police, schools and other organisations that work with children must follow, and emphasises that safeguarding is the responsibility of all professionals who work with children.

It also supports Prof. Munro’s findings that a child-centred approach must be adopted by children’s services. The needs of the individual child must be identified and prioritised and their views sought and considered.

And the principle that early help is effective in promoting the welfare of children and keeping them safe as it is preventative - reducing the need for statutory intervention.

The Working Together document is statutory guidance and therefore all professionals working with children and families should make time to read this document and work out within their teams, services and organisations how to implement the principles outlined, in relation to their own work.

Available to download at [www.gov.uk](http://www.gov.uk)
Foreword

This guide has been produced to support and promote effective early identification of needs and to assist professionals in deciding how best to help and protect children and young people.

This version of the guide replaces the one issued in 2014. We will revise the guide again periodically to ensure latest legislation, policy and practice changes are reflected, so please check you are using the most up to date version. This can be found online at Ealing Safeguarding Children Board’s website www.ealingscb.org.uk

The assessment protocol explains what assessments are carried out at each threshold of need – their process, purpose, the services involved, how to make a referral and what happens next.

This guide also promotes Ealing’s drive to ensure effective delivery of early help. It explains what is meant by ‘early help’ as well as the EHAP (Early Help Assessment and Plan) - our multi-agency single assessment of need (which replaced the Common Assessment Framework).

Can you identify a child in need?
‘Child in need’ is a popular phrase, used by a number of services and organisations both locally and nationally and in a number of different circumstances. In this guide we look at the definition taken from the Children Act 1989 and highlight key indicators and observations to help you identify a child in need at every level - from risk to general wellbeing right through to a safeguarding concern.

I hope you find this guide accessible, useful and informative.

Thank you for your continued hard work and commitment to the welfare of Ealing’s children and young people.

Judith Finlay
Executive Director
Children, Adults & Public Health
Ealing Council
Useful reference

Ealing’s Early Help Assessment and Plan (EHAP)
An assessment process to deliver early multi-agency and targeted support to children and families.
www.ealing.gov.uk/EHAP

The London Child Protection Procedures
www.londoncp.co.uk

The London Safeguarding Children Board (LSCB) has recently published revised procedural guidance on the following:
• Safeguarding Children Exposed to Extremist Ideology, Practice Guidance
• Safeguarding Children From Sexual Exploitation, Practice Guidance
• Safeguarding Girls from Risk of Abuse through Female Genital Mutilation, Practice Guidance
Available at www.londoncp.co.uk or www.ealingscb.org.uk (under ‘Forms of Abuse’)

Mandatory Reporting of Female Genital Mutilation – procedural information

The Children Act 1989 – link below takes you to a very accessible version of the act breaking down the parts and sections.

Section 11 of the Children Act 2004 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children.
www.legislation.gov.uk/ukpga/2004/31/section/11

Ealing Child Protection Procedures, Guidance for Voluntary, Community and Private Sector Organisations
www.ealingscb.org.uk

Quick Guide to Ealing Family Support Services
A service directory for professionals working with children and families and wishing to access relevant services.
Family Services at www.ealingfamiliesdirectory.org.uk

The Family Services Directory is an online, searchable resource for services and organisations in and around Ealing, including some national. From here you can also access the SEND Local Offer online resource.
www.ealingfamilies.org.uk

Ealing Safeguarding Children Board (ESCB)
www.ealingscb.org.uk

A key website to visit for all legislative guidance and codes of practice is www.legislation.gov.uk. It is accessible in that the guidance is broken up into sections then explained and referenced clearly.
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## Glossary of terms and abbreviations

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<th>Definition</th>
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<tr>
<td>CAMHS</td>
<td>Children and Adolescent Mental Health Services</td>
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<tr>
<td>CFA</td>
<td>Child and Family Assessment (used by Children's Social Care Locality Team)</td>
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<tr>
<td>Child(ren)</td>
<td>Refers to a child at any age and up to 18 years-of-age (including unborns).</td>
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<tr>
<td>Children's Social Care</td>
<td>Means Children's Social Work Service.</td>
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<tr>
<td>CPA</td>
<td>Child Protection Adviser</td>
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<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>Development</td>
<td>Means physical, intellectual, emotional, social or behavioural development.</td>
</tr>
<tr>
<td>DO</td>
<td>Designated Officer (Safeguarding) formerly known as LADO</td>
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<tr>
<td>ECIRS</td>
<td>Ealing Children's Integrated Response Service</td>
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<tr>
<td>EHAP</td>
<td>Early Help Assessment and Plan</td>
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<tr>
<td>ESCAN</td>
<td>Ealing Service for Children with Additional Needs</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>Harm</td>
<td>Means ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill-treatment of another.</td>
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<tr>
<td>Health</td>
<td>Means physical or mental health.</td>
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<tr>
<td>IRO</td>
<td>Independent Review Officer (Social Care)</td>
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<tr>
<td>MASH</td>
<td>Multi-Agency Safeguarding Hub</td>
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<tr>
<td>NEET</td>
<td>Not in Education, Employment or Training</td>
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<tr>
<td>Parent</td>
<td>Refers to a parent, carer, legal guardian or any other adult with parental responsibility for the child.</td>
</tr>
<tr>
<td>Practitioner</td>
<td>Is used to refer to anyone who works with children and families.</td>
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<tr>
<td>Protocol</td>
<td>An agreed code of practice or procedure for doing something.</td>
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<tr>
<td>S.17</td>
<td>Section 17 of Children Act 1989; Provision of services for children in need.</td>
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<tr>
<td>S.47</td>
<td>Section 47 of Children Act 1989; the local authority's duty to investigate where there is reason to believe a child has suffered or is likely to suffer significant harm.</td>
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<tr>
<td>SEN</td>
<td>Special Educational Needs</td>
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<tr>
<td>SEND</td>
<td>Special Educational Needs and Disability</td>
</tr>
<tr>
<td>EHC</td>
<td>Education, Health and Care (EHC) plan. EHC Plans are replacing Statements of Special Educational Need (SEN) and Learning Difficulty Assessments.</td>
</tr>
<tr>
<td>TAF</td>
<td>Team Around the Family - a meeting in which professionals fully include the family.</td>
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<tr>
<td>WLMHT</td>
<td>West London Mental Health Trust</td>
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<tr>
<td>YJS</td>
<td>Youth Justice Service</td>
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</table>
What do we mean by early help?

Early help means early intervention – at the point when a problem or issue is emerging.

At this point, appropriate help delivered in a timely and efficient way has the best chance of ensuring a long-term positive result, reducing or eliminating the need for statutory intervention.

Early help should be offered to children and families experiencing some difficulties that are adversely affecting the child’s development and life; but do not meet the threshold levels for intervention by the Children’s Social Care Locality Teams.

If a single service can provide all the support needed, or if the threshold of need level is Level 1: Universal – the child and their family can access the required service directly and where appropriate or possible – with the support of professionals they are already working with, i.e. from school or health services.

Where there is a need for multi-agency or multi-disciplinary, or targeted support, that crosses over into threshold Levels 2 and 3 – an EHAP (Early Help Assessment and Plan) should be initiated and completed to achieve the desired results.
ECIRS (Ealing Children’s Integrated Response Service)

If at any time you become concerned that a child has been harmed or is at risk of harm - call ECIRS immediately on 020 8825 8000 (24hrs for emergency calls).

ECIRS is the single point of entry for all professional referrals and self-referrals in Ealing for both urgent and non-urgent cases, including for families wishing to self-refer to SAFE.

A single point of entry provides an effective way of ensuring a child gets the right help at the right time as soon as a concern is raised. It also reduces the need for information sharing between different services which guards against children ‘slipping through the net’.

The ECIRS team comprises of a team manager, three deputy team managers, social workers, family support workers and business support officers. When an individual first calls ECIRS they will speak to a business support officer who will obtain an overview of the enquiry. In the case of a safeguarding referral, the caller has the opportunity to speak to a social worker who will note the concerns and advise the next steps.

What happens next?

For urgent cases where there are concerns that a child has been harmed or is at risk of immediate harm - ECIRS will make a referral to one of the Children’s Social Care Locality Teams who will take appropriate and immediate action.

The referrer will be asked to provide the following information:

- Child’s basic details (name, address, DOB, ethnicity, etc.)
- Details of siblings if known (name, gender and age)
- Details of parents and/or other adults in the household who may have parental responsibility for the child
- A summary of the contact your agency has had with the child (where applicable)
- An overview of the child/family’s EHAP (if one exists)
- If anyone has spoken to the child – what they said
- Your assessment of the child’s development and progress
- Whether you obtained parental consent to share information for the purposes of a referral to ECIRS.

For non-urgent cases where a child is in need and the situation has the potential to turn into a safeguarding concern or where there is a safeguarding concern but one that does not warrant immediate action - ECIRS will make a referral to the locality teams for a CFA (Child and Family Assessment) and further investigation.

ECIRS is also able to access specialist and/or targeted services such as SAFE, Youth Justice Service, ESCAN etc in response to identified needs.
For non-urgent cases where a child is identified as a ‘child in need’ (see definition on page 13), a professional referrer will be asked to provide a copy of the child/family’s EHAP in order to make a referral.

The importance of an EHAP for an ECIRS referral
For non-urgent cases where a professional has not attempted identification and delivery of early help through an EHAP – in most cases they will be asked to do so before ECIRS can accept the referral.

The idea of this is that all services, especially those closest to the child and family, are fully engaged and supportive in trying to provide early help wherever possible and appropriate.

This offers greater potential for the help to be immediate, appropriate and engaging. The child and family are more likely to engage and participate in achieving a better outcome for themselves - if they are offered early help working with professionals they already know and trust.

If an EHAP is completed but not successful or if the threshold of need escalates, a referral can be made to ECIRS, using the EHAP as a starting point to demonstrate what needs have been identified, what action was taken and the outcome.
EHAP (Early Help Assessment and Plan)

The EHAP is a way of working whereby the child and their family engage with practitioners to assess their needs and work out an action plan for how those needs will be met. The action plan is reviewed and updated until needs are satisfactorily met and the process ends.

The process begins by the practitioner identifying that a child may have needs which may impact on their development and their life; which cannot be met by a single service and require a multi-agency, multi-disciplinary or targeted approach to reach the desired result.

The practitioner becomes the EHAP Initiator once they have spoken to the child and their family, obtained consent to initiate the EHAP process, recorded the child and family’s identifying details on the EHAP form and registered the EHAP with the Family Information Service.

The EHAP Initiator then convenes a TAF (Team Around the Family) meeting, inviting the child, family and appropriate practitioners from services most likely to be needed (based on presenting issues). At the meeting a Lead Professional is agreed and this person will progress the EHAP, working closely with the family.

An EHAP in progress (or once completed) offers important insight into the family’s own perception of their situation, the assessment of need carried out by practitioners closest to the child and their family, the presenting issue(s), family situation, family structure, ethnicity etc. The EHAP will show what measures and actions were decided and what progress has been made.

Delivering early help through the EHAP process is crucial to address a concern before it becomes more serious and detrimental to the child’s development. It also plays a vital role in providing other services such as ECIRS and Children’s Social Care Locality Team with a better understanding of the child and family, should the threshold of need escalate to a need for Level 3 or Level 4 services.

This reduces duplication and increases efficiency by informing services what measures have already been tried, what worked best, and what was less successful. This will ensure any subsequent service delivery or decisions about the case are based on actual experience and a better understanding of the child and their family.
Find out more and make the EHAP a part of your working practice
The EHAP works on a very simple concept of identification, planning and action. The process is outlined in full, with example case studies and example completed assessments in the Quick Guide to The Early Help Assessment and Plan (EHAP) which is provided as part of the EHAP Pack.

The EHAP Pack contains all the necessary information and forms to enable you to use the EHAP process and is available to download at [www.ealing.gov.uk/EHAP](http://www.ealing.gov.uk/EHAP) or in print by emailing your details to EHAP@ealing.gov.uk
The assessment framework

The diagram below is an effective assessment tool, guiding you through a systematic way to undertake an assessment whilst placing the child and their family at the heart of the process.

The framework sets out the key areas of assessment under three main headings: development of the unborn baby/child/young person, parents and carers (looking at parenting capacity), family and environment.

Not all areas will be relevant to each assessment undertaken. However, each area should be considered to ensure a complete assessment of needs.

This framework can be used at any assessment level from use of the EHAP (Early Help Assessment and Plan) right through to a Child and Family Assessment (CFA) used by social care.

Assessment framework diagram

This diagram is adapted from the Working Together to Safeguard Children guidance and provided as a portable assessment tool within the EHAP Pack.
Identifying a child in need

Under S17 Children Act 1989 a child is ‘in need’ if the child is unlikely to achieve or maintain a reasonable standard of health or development without the provision of services through the Local Authority, or the child’s health or development is likely to be significantly impaired without the provision of such services, or the child is disabled.

Safeguarding children first and foremost means that if a child has been harmed or abused or is at risk of being harmed or abused children’s services must be notified immediately for appropriate action to be taken.

However, if the concern for a child is more about their general wellbeing once there is indication that all is not as it should be, taking action early to address an emerging issue is key to preventing the situation taking hold and having a detrimental, longer-term effect on the child.

Also, the initial presenting issue may in fact uncover a safeguarding concern or develop into one. Either way, early identification of a child in need and the delivery of appropriate support are essential.

Observations that could indicate a child is in need:
(This is not an exhaustive list and should be used together with your professional judgement, knowledge of each child and their family, and your organisation’s safeguarding measures.)

• Where a practitioner observes a significant change or worrying feature in a child/young person’s appearance, demeanour or behaviour. This can include a change in the way they dress.
• A change in general wellbeing and social interaction with others, including withdrawing from friends.
• Persistent non/late attendance at childcare or school
• Regularly being without necessary equipment or clothing such as a PE kit, a coat in cold weather etc.
  Or a sudden change in their possessions such as having new clothing, accessories and equipment they didn’t have before or may not be able to afford.
• A child who appears hungry or where a packed lunch or means of buying lunch have not been provided
• Where a practitioner knows of a significant event in the child/young person’s life that may have a negative impact such as divorce or bereavement
• Where there are worries about the family’s home environment
• Missing developmental milestones or making slower progress than expected
• A child presenting challenging or aggressive behaviour
• Experiencing physical or mental ill health or disability (either their own or within their family)
• Exposure to drugs/substance misuse or violence within the family
• Having to undertake caring responsibilities
• Experiencing family breakdown
• A child who is being bullied or has become a bully
• A child who is suffering discrimination or disadvantage for reasons such as race, gender, sexuality, religious belief or disability or who becomes discriminatory towards others.
• A child who has become homeless/is living in temporary accommodation
• A young person expecting a baby or who is already a teenage parent
• A child experiencing neglect (for guidance on spotting neglect as well as other indicators of child abuse please refer to the London Child Protection Procedures www.londonscb.co.uk)
Determining if a case is safeguarding or a child in need

Children’s Social Care use the ‘London Child Protection Procedures: Threshold Document: Continuum of Help and Support’ to assist in decision making about threshold of needs and response. The table below is a summary guide (not exhaustive) that illustrates some of the differences between Section 47 (child protection) and S17 (child in need). Decisions about threshold of need and response will always be made taking account of the age/vulnerability of the child; previous history, any disability or developmental delay and all available relevant information.

<table>
<thead>
<tr>
<th>Section 47</th>
<th>Section 17</th>
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<tr>
<td>Any allegation of abuse or neglect or any suspicious injury into an infant who is pre-mobile (not yet mobile / crawling / walking).</td>
<td>Allegation of physical assault with no visible or only minor injury (other than to a pre-or non-mobile child).</td>
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<tr>
<td>Allegations or suspicions about a serious injury or sexual abuse of a child.</td>
<td>Any injury / incident triggering concern (e.g. a series of apparently accidental injuries or a minor non-accidental incident).</td>
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<tr>
<td>Two or more minor injuries in pre-mobile or non-verbal babies or young children (including disabled children).</td>
<td>Any incident / injury triggering concern (e.g. a series of apparently accidental injuries or a minor non-accidental incident).</td>
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<tr>
<td>Inconsistent explanations or an admission about a clear non-accidental injury.</td>
<td>Repeatedly expressed minor concerns from one or more sources.</td>
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<tr>
<td>Repeated allegations or reasonable suspicions of non-accidental injury.</td>
<td>Level 3 domestic violence (see Barnardos Domestic Violence Matrix p.42).</td>
</tr>
<tr>
<td>A child being traumatised injured or neglected as a result of domestic violence.</td>
<td>Allegation concerning serious verbal threats to children.</td>
</tr>
<tr>
<td>Repeated allegations involving serious verbal threats and/or emotional abuse.</td>
<td>Allegations of emotional abuse including that caused by minor domestic violence.</td>
</tr>
<tr>
<td>Allegations / reasonable suspicions of serious neglect.</td>
<td>Allegations of periodic neglect including insufficient supervision; poor hygiene, clothing or nutrition; failure to seek / attend treatment or appointments; young carers undertaking intimate personal care.</td>
</tr>
<tr>
<td>Medical referral of non-organic failure to thrive in under-fives.</td>
<td>Suspicions of sexual abuse (e.g. sexualised behaviour, medical concerns or referral by concerned relative, neighbour, carer).</td>
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<tr>
<td>Direct allegation of sexual abuse made by child or abuser’s confession to such abuse.</td>
<td>No available parent, child in need of accommodation with no specific risk if this need is met.</td>
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<tr>
<td>Any allegation suggesting connections between sexually abused children in different families or more than one abuser.</td>
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<tr>
<td>An individual (adult or child) posing a risk to children.</td>
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<tr>
<td>Any suspicious injury or allegation involving a child subject of a current child protection plan or looked after by a local authority.</td>
<td></td>
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<tr>
<td>No available parent and child vulnerable to significant harm (e.g. an abandoned baby).</td>
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<tr>
<td>Suspicion that the child has suffered or is at risk of significant harm due to fabricated or induced illness.</td>
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<tr>
<td>Where a child is the subject of parental delusions.</td>
<td></td>
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<tr>
<td>A child at risk of sexual exploitation or trafficking.</td>
<td></td>
</tr>
<tr>
<td>Registered sex offender or convicted violent offender subject to MAPPA moving into a household with under 18 year olds.</td>
<td></td>
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<tr>
<td>Pregnancy in a child aged under the age of 13.</td>
<td></td>
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<tr>
<td>A child at risk of FGM, honour based violence forced marriage or other gender based harm.</td>
<td></td>
</tr>
<tr>
<td>Missing children who are at risk of sexual exploitation and/or physical violence.</td>
<td>Missing children who do not go missing frequently or for long periods and there are no concerns about their social contacts.</td>
</tr>
</tbody>
</table>
When will Children’s Social Care get involved?

The key question which guides the response from Children’s Social Care is: **how serious and how immediate** is the concern?

ECIRS will screen cases to identify whether Children’s Social Care should take further action under its powers - S17 provision of services for children in need or S47 local authority’s duty to investigate for children ‘suffering or likely to suffer significant harm …’ (Children Act 1989).

There is no absolute definition of ‘significant harm’ but the London Child Protection Procedures (2015) suggest the following should be considered:

(Excerpt) **the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements…** Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning). More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child’s physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term neglect, emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

In terms of working practice, decisions regarding the threshold for statutory intervention rest with the manager of ECIRS or the manager of the relevant child care team e.g. Locality team, Children with Disabilities team.

Ealing’s Multi-Agency Safeguarding Hub (MASH) which sits within ECIRS assists in the making of Threshold decisions. The manager is required to record and evidence the basis for their decision on the child’s file.

The assessment framework and threshold levels detailed in this guide set out the factors that can influence the determination of the level of need, how this is assessed and other factors taken into consideration, such as age and developmental vulnerability.
Children in special circumstances

Children with Special Educational Needs (SEN)
All early years settings and schools have a Special Educational Needs Coordinator (SENCO) or Inclusion Manager. It is their responsibility to coordinate support for children in their setting and to liaise with other professionals to ensure children’s needs are planned for. All schools receive additional funding to enable them to set up a range of provision to meet children’s special educational needs. Colleges and other higher education settings have the same responsibility towards any young people up to the age of 25 with SEN requirements attending their provision.

A statutory assessment of education, health and care is a coordinated multi-disciplinary assessment carried out for children and young people age 0-25 with severe and complex special educational needs under the Children and Families Act 2014. The coordinated assessment determines whether an Education, Health and Care (EHC) Plan is needed. An EHC Plan is a legal document setting out the education, health and care needs of the child, the outcomes expected and all of the education, health and care provision required to achieve the outcomes. EHC Plans are replacing Statements of Special Educational Need and Learning Difficulty Assessments.

Referral and assessment for Children with a disability including those who also have a statement of SEN or an EHC plan
Referrals go through ECIRS, who will decide if the child should be referred to the Children with Disabilities (CWD) Team within ESCAN. The CWD team will be responsible for referrals of children with a severe or profound disability and complex needs. This includes children with a physical or learning disability, complex health needs or those on the Autistic Spectrum.

Children with a disability are assessed according to the impact the impairment has on their quality of life and that of their family. Help is designed to be family-centred and promote social inclusion.

Where it appears that the child is unlikely to achieve good outcomes without a multi-agency approach - an EHAP (Early Help Assessment and Plan) will be initiated to better coordinate the necessary help and support and to obtain and understand the child’s views and that of their family (where possible and using specialist communication skills and techniques if necessary).

Disabled children who require higher level targeted or specialist services will have a CFA (Child and Family Assessment) completed by a social worker from the Children with Disabilities Team who will coordinate and review any child in need or care plan put in place for the child.

There is evidence to suggest that disabled children are more likely than other children to suffer abuse and neglect especially when affected by multiple disabilities. If it is suspected that the child is suffering or likely to suffer significant harm a social worker from the Children with Disabilities Team will carry out a Section 47 investigation.

In cases where the child has a health issue, a referral can be made direct to the relevant service through the child’s GP or other health professional working with the child. This includes referrals to Occupational Therapy, Physiotherapy and Community Nursing Service etc.
Self-referrals (i.e. those made by the parents or carers) can only be made to Speech and Language Therapy.

Parents and carers of a child with disabilities have the right to request a statutory assessment under the Carers and Disabled Children Act 2000. This assessment will be undertaken by the Children with Disabilities Team.

There are duties in the Children and Families Act 2014 for children and young people aged from 0 to 25 years with severe and complex special educational needs.

1. A coordinated statutory assessment process for children and young people aged 0-25 that may result in an EHC (Education, Health and Care plan). EHC plans will replace Statements of SEN and Learning Difficulty Assessments (LDA).
2. A Local Offer will be published showing the education, health and care provision available in the borough for children and young people with SEN or disabilities. (Now available at www.ealingfamiliesdirectory.org.uk)
3. Direct payments enabling greater choice in how funding is used to provide care services.

Children who return home from care
Children return home from the care of the Local Authority under different circumstances:

a) Where they have been accommodated by the Council under voluntary arrangements with the parents but not for reasons of abuse or neglect.

b) Where they have been accommodated with the agreement of the parents as a result of child protection concerns (abuse or neglect).

In this instance children are likely to need a child protection plan which is decided at a Child Protection Conference. A Child and Family Assessment (CFA) will be carried out to assess any risk to the child returning home. Children who have been subject to a Care Order because of abuse or neglect and are then returned home are some of the most vulnerable of all as research shows worryingly high levels of repeat abuse.

Unless the Council obtains a court order or the parents agree to the continued accommodation of the children with the Council, children are returned home while these assessments take place.

c) Children who have been taken into care for up to 72 hours following Police invoking their powers of protection under Section 46 of the Children Act 1989 ‘Removal and accommodation of children by police in cases of emergency’.

d) Children’s Social Care will need to assess whether there are grounds to seek a court order to prevent the child returning home before the expiry of the 72 hour period. There is not enough time to complete a CFA but the decision to allow the child to return home or make an application to court will be taken by the Senior Manager for the Locality Team or another Senior/Operations Manager after consultation with the police and any other agencies involved with the child.
Children subject to an Interim Care Order or a Care Order will only be returned home from care:

a) If it is evident that the abuse or neglect that led to the child coming into care is very unlikely to re-occur.
b) If the parents have engaged with and positively used the help offered to deal with the problems that led to the child coming into care.
c) Subject to agreement at the child’s LAC review.
d) Following full consultation with all professionals who know the child and parents.
e) Fully taking into account the foster carer’s (or other carer’s) views as they will usually know the child best.
f) Following the formulation of a robust plan to monitor the child’s welfare, provide help to the child and parents and reduce the level of future risk.
g) Once the Senior/Operational Manager for the Children’s Social Care Locality Team has been consulted and has approved the CFA.

If the decision to return the child home is finely balanced or there is disagreement amongst professionals (including the foster carer) or the assessment concludes the risks are high – the Senior/Operational Manager will chair a network meeting, including the Independent Review Officer (IRO) to review the evidence and make a recommendation to the Assistant Director, Safeguarding and Support, Ealing Children’s Services.

If it is deemed that the child needs a Child Protection Plan - a Child Protection Conference will be convened.

The agreement of the Assistant Director, Safeguarding and Support has to be obtained and all requirements of the Care Planning, Placement and Care Review Regulations 2015 must be met.

If a child is still subject to care proceedings and an Interim Care Order has been made, the decision to return home rests with the Court. The Court may also direct that a child returns home before all the above steps can be completed. In such circumstances the social worker will inform the court that all internal procedures have not been completed. However, even if the Council cannot support the decision - the Locality Team may offer or be required to provide support once the child has returned home.
Young carers
Young carers are children who have daily care responsibilities for a family member with a disability (physical or mental), long-term illness or with substance misuse issues.

Young carers are particularly vulnerable as many are ‘hidden’ due to the stigma attached to the conditions they are supporting. Some do not come forward because they and their families are frightened of outside intervention and the fear they may be split up. Many children will not even tell a teacher or a friend.

Being a young carer can have a dramatic effect on the life of a child. Their health is often severely affected due to lack of sleep and the amount of household chores and physical care undertaken. Young carers also face developmental challenges in terms of meeting their educational targets and their social and emotional wellbeing. Their lives outside of school are very different to their peers and therefore they may feel lonely and isolated and in some cases suffer verbal taunts and abuse at school.

In Ealing, we have adopted the ‘No Wrong Doors: Working Together to Safeguard Children’ principles (Issued by the DH and DfE 2015). These stipulate that young carers should be identified, assessed and their families supported regardless of which service is contacted initially (hence the assertion that there should be ‘No Wrong Doors’).

Professionals will work together across services to ensure young carers’ needs are assessed using a ‘whole family’ approach. Assessments will ascertain why a child is caring and what needs to change in order to prevent them from undertaking excessive or inappropriate caring responsibilities which could impact adversely on their wellbeing, education, or social development.

This duty of care has been adopted in addition to responsibilities placed on the local authority set out in The Children’s Act 1989 (and amended by the Children and Families Act 2014).

Any professional who comes into contact with a young carer, should offer the young carer and their family the opportunity of having an assessment. If there are immediate concerns about the wellbeing of a young carer - professionals should make a referral to ECIRS who will give advice and progress the referral appropriately.

ECIRS are likely to refer young carers to SAFE, unless they have additional needs such as being at risk of or actually experiencing significant harm.

There is a question about whether a child is a young carer on the EHAP form under ‘identifying details’. Professionals who initiate an EHAP for a child should sensitively try to ascertain whether the child is involved in daily caring duties and note this on the EHAP form where indicated. This will then trigger appropriate questions and subsequent actions within the EHAP process and assessment.
**Children involved in the youth justice system**

Children involved in the youth justice system will be known to the Youth Justice Service (YJS) who undertake a range of work to reduce the risk of reoffending, including working with their families.

The YJS use specialist assessment tools in relation to children referred from the courts, police or other agencies. As part of their assessment they will check if the child or family is known to Children’s Social Care Locality Team. They will also consider whether the child has specific needs and would benefit from a referral to SAFE or Children’s Social Care Locality Team. In cases where the child has suffered abuse or neglect or is at risk of significant harm - they will be referred to Children’s Social Care Locality Team.

The assessment also covers the child’s education, training and employment (ETE) status and any special educational needs. The YJS officer will liaise with colleagues in schools, colleges and the SEN Team where appropriate. Physical and mental health is also part of the assessment process - checks will be made with health colleagues in relation to any concerns the child may be presenting with.

**Children who go missing from home, care or school**

Children who go missing even for a short period can be vulnerable to significant harm. There are particular concerns about the links between children who go missing and the risk of sexual exploitation. Children who are looked after and go missing from their placements are exceptionally vulnerable.

A child going missing from school could also be an indication that the child has experienced harm or abuse or is at serious risk. In addition to the impact on academic achievement you should consider if there are other risk factors such as a potential forced marriage or female genital mutilation (FGM) which may be influencing the absence from school.

If you become concerned about a child going missing you should contact ECIRS.

**Children at risk of sexual exploitation**

Child sexual exploitation (CSE) involves exploitative situations, contexts and relationships where the child or someone close to them receives a ‘reward’ e.g. food, accommodation, drugs, alcohol, cigarettes, affection, money, gifts etc. in exchange for performing sexual acts. There is an established link between children who are missing and sexual exploitation.

CSE can occur through the use of technology i.e. through social media without the child’s immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones.

Violence, coercion and intimidation are common aspects of CSE. Involvement in exploitative relationships is characterised by the child’s limited availability of choice resulting from their social, economic or emotional vulnerability.

Often the child does not recognise the coercive nature of an exploitative relationship and does not see themselves as a victim of exploitation. The child might believe their abuser is in a genuine relationship with them and loves them. They may be unwilling to say anything that could get the abuser into trouble or cause them to become angry, affecting the relationship.
In some situations, such as in gangs, there may be the belief that the abuse is normal and a rite of passage. Girls and young women related to or connected with male gang members may be vulnerable to sexual violence and exploitation.

Any concerns about CSE should be referred to ECIRS.

London Safeguarding Children Board procedural guidance ‘Safeguarding Children from Sexual Exploitation: Practice Guidance’ can be found at [www.londoncp.co.uk/files/sg_ch_sexual_exploitation.pdf](http://www.londoncp.co.uk/files/sg_ch_sexual_exploitation.pdf)

Ealing’s CSE Risk Assessment Toolkit can be found on page 49. This is taken from the ESCB Tackling Child Sexual Exploitation guidance found at [www.ealingscb.org.uk](http://www.ealingscb.org.uk)

The purpose of the CSE guidance and toolkit is to enable professionals to assess a child or young person’s level of risk in a quick and consistent manner.

**Children at risk or who have suffered Female Genital Mutilation (FGM)**

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-medical purposes. Procedures are extremely painful and have serious health consequences, both at the time when the mutilation is carried out and later in life.

FGM is prevalent in 28 African countries as well as parts of the Middle East and Asia.

It is estimated that over 20,000 girls under the age of 15 are at high risk of FGM in the UK each year and that 66,000 women in the UK are living with the consequences, although the true extent is unknown due to the hidden nature of the crime.

Under the Female Genital Mutilation Act 2003 it is an offence to carry out FGM of any kind in the UK or for a UK national or permanent UK resident to assist in the carrying out of FGM abroad. It is also an offence to assist any female to carry out FGM on herself either in the UK or abroad.

**Mandatory Reporting of Female Genital Mutilation [FGM]**

The Mandatory Reporting of FGM Duty came into force on 31st October 2015

This duty requires regulated health and social care professionals and teachers in England and Wales to personally report to the Police on 101 when she/he has either been told by a girl that she has had FGM or has observed a physical sign appearing to show that a girl has had FGM.

In all other cases, professionals should follow normal safeguarding processes.

For further information please refer to the recently published Home Office statutory guidance ‘Mandatory Reporting of Female Genital Mutilation’ and London Safeguarding Children Board procedural guidance ‘Safeguarding Girls at Risk of Abuse through Female Genital Mutilation (FGM): Practice Guidance’

Note the flow chart published by DH / NHSE ‘FGM Mandatory reporting duty’. [www.londoncp.co.uk/files/sg_ch_from_fgm.pdf](http://www.londoncp.co.uk/files/sg_ch_from_fgm.pdf)
Identifying girls at risk
The age at which girls undergo FGM varies enormously according to their community and culture. The procedure may be carried out when the girl is newborn, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of five and eight and therefore girls within that age bracket are at a higher risk.

Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in the summer holidays, in order for there to be sufficient time for recovery before the new term.

Indications that FGM may be about to take place
- Families may practise FGM in the UK when an elder female family member is around, particularly when she is visiting from the country of origin
- A professional may hear references to FGM in conversations between children
- A girl may confide that she is to have a ‘special procedure’ or to attend a special occasion to ‘become a woman’
- A girl may request help from a teacher or other adult if she becomes aware of the possibility or suspects she is at risk
- Parents taking the child out of the country for a prolonged period.

Indications that FGM may have already taken place
- A girl may have difficulty in walking, sitting or standing
- A girl may take longer than normal in the toilet due to difficulties urinating
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems
- Frequent urinary or menstrual problems
- Prolonged or repeated absence from school or college
- Prolonged absence followed by noticeable behaviour changes (e.g. withdrawal or depression)
- Reluctance to undergo any normal or routine medical examination
- A girl may ask for help but may not be explicit about the problem due to embarrassment or fear.

Awareness, identification and action
It is important to be aware of the possibility of FGM within communities and for professionals to be vigilant to indicators.

Professionals in Ealing who are worried that a child is at risk of FGM or has been subjected to FGM should contact ECIRS who will determine how to progress the concern.

Professionals who have daily contact with children and their families are also best placed to raise awareness of the problem and to ensure that families are aware that FGM is illegal at any age and that the authorities are actively tackling the issue. It is not down to personal choice – it is an illegal act with serious consequences. This awareness may deter families from having FGM performed on their children.
Children at risk of radicalisation and exposure to extremist ideology

Radicalisation is when people come to support extreme ideologies based on the teachings of political, social and religious groups.

In some cases, those with extremist views will specifically target children because they believe them to be more impressionable and willing to follow their teachings. A child may be more willing to join an extreme group because it may give them a sense of identity and ‘belonging’. Young people may be attracted to an ideology and particular group because they believe it will lead to adventure and excitement.

Joining extremist groups can lead to trouble with the police, involvement in acts of violence and in extreme cases - travelling abroad to fight in or support conflict overseas. It is important to recognise the early signs of radicalisation in order to decide the best intervention, working together with parents/carers and the child’s school.

Indicators or changes in behaviour to look out for include:

- Losing interest in old friendship groups in favour of new ones
- Secretive behaviour
- Sudden changes in dress, behaviour and relationships with others
- Defending acts of terrorism around the world
- Talking about violence as a way of making a social or political statement
- Possessing magazines and books carrying extremist messages or detailing the construction of weapons.
- Sharing messages on social media or ‘following’ organisations involved in extremist behaviour or promoting extremist ideology.
- A behaviour change that indicates the heavy influence of others or mimics those within the extremist group. For example some groups may encourage anti-social behaviour and this may become evident at home or in the classroom.
- Some groups work very secretively and may ask a child not to draw attention to themselves.

Children may therefore suddenly become better behaved at school and their grades may improve. They may begin dressing more modestly and become quieter.

Often these behavioural changes will come from physical interaction with a group rather than online communication. This may be a sign of increased interest in extremist views.

Professionals who are worried about a child or group of children being exposed to extremist ideology or groups that may put them at risk of radicalisation, should contact ECIRS to discuss their concerns and where appropriate make a referral.

London Safeguarding Children Board procedural guidance ‘Safeguarding Children Exposed to Extremist Ideology: Practice Guidance’ can be found at: www.londoncp.co.uk/files/sg_chExposedExtremIdeology.pdf
**Private fostering**

A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of a Local Authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

Private foster carers may be from the extended family, such as a cousin or great aunt. A person who is recognised as a close relative under the Children Act 1989 i.e. a grandparent, brother, sister, uncle or aunt (whether of full or half blood or by marriage) or step-parent is not considered to be a private foster carer.

A private foster carer may be a friend of the family, the parent of a friend of the child, or someone previously unknown to the child’s family who is willing to privately foster a child. The period for which the child is cared for and accommodated by the private foster carer should be continuous, but that continuity is not broken by the occasional short break.

Local Authorities do not formally approve or register private foster carers. However, it is the duty of the LA to ensure they are satisfied that the welfare of children who are privately fostered is being satisfactorily safeguarded and promoted.

Private fostering includes:

- Children living with a friend, or the family of girlfriend/boyfriend
- Children who have come to the country for medical treatment, exchange holidays or language courses
- Children being cared for while a parent is in prison or hospital.

Professionals who work with children often come across private fostering arrangements as part of their day-to-day work.

If you become concerned about private fostering arrangements contact ECIRS.

ECIRS will refer to the Housing Support Team who will undertake an assessment. If there is a safeguarding concern, the case will be referred to the Children’s Social Care Locality Team.
# Ealing’s assessment process flowchart (Levels 2, 3 and 4)

## Level 2
Concerns that a child is in need.

## Level 3
Concerns that a child may have complex needs or other factors exist that may turn into a safeguarding issue.

## Level 4
Concerns that a child is suffering or is likely to suffer harm or abuse.

### Appropriate referral and response

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Early help through an EHAP.</td>
</tr>
<tr>
<td>Level 3</td>
<td>EHAP and/or referral to ECIRS.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Referral to ECIRS.</td>
</tr>
</tbody>
</table>

### Information sharing and consent

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Seek consent to initiate an EHAP.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Seek consent to initiate an EHAP and/or make a referral to ECIRS.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Inform the family that a referral is being made to ECIRS unless it is detrimental to the child to do so (see page 44).</td>
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</tbody>
</table>

### What happens next

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Progress the EHAP seeking advice from the Family Information Service or ECIRS if necessary.</td>
</tr>
<tr>
<td>Level 3</td>
<td>ECIRS decide case threshold levels i.e. towards targeted or specialist services such as SAFE, ESCAN or the Hospital Team or immediate safeguarding intervention Children’s Social Care Locality Team and/or the police.</td>
</tr>
</tbody>
</table>

### Possible outcomes

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>EHAP demonstrates evidence for case closure. EHAP demonstrates that threshold level escalates to referral to ECIRS</td>
</tr>
<tr>
<td>Level 3</td>
<td>Case is screened, advice given and no further action taken. Referrer is asked to complete an EHAP for the child and family in the first instance. For a child in need who has reached threshold Level 3, referral for a Child and Family Assessment (CFA) or a Child in Need Plan.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Police Child Abuse and Investigation Team (CAIT) consulted and if satisfactory grounds are met (para 2) a Section 47 investigation is completed by a social worker from the locality team and recorded on Frameworki. Substantiated concerns result in Child Protection Conference and possibly a Child Protection Plan.</td>
</tr>
</tbody>
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*At any time concerns/risks can change and be escalated/de-escalated*.
Ealing’s assessment processes

The following sections describe the assessment processes across all of Ealing Children’s Services including ECIRS, Children’s Social Care Locality Team, SAFE and other specialist services.

**ECIRS (Ealing Children’s Integrated Response Service)**
When you contact or refer to ECIRS for a safeguarding/child protection concern - there are a number of actions based on the legal framework set out in section 47, Children Act 1989, that can be taken.

1. If the statutory criteria for initiating an investigation under Section 47 are established i.e. the child has suffered or is likely to suffer significant harm; Children’s Social Care Locality Team can undertake a **child protection investigation**.
2. In children in need cases where there is a risk to the child’s development a referral is made to the Hospital Team, Housing Support Team or ESCAN who can undertake a **CFA (Child and Family Assessment)** for a child in need.
3. Where there are concerns about domestic abuse, child behaviour and mental wellbeing, SAFE may be asked to offer support. A needs assessment will be carried out using the **SAFE Assessment and Plan**.
4. Take **No Further Action (NFA)** if the referral does not meet the threshold for intervention by the Children’s Social Care Locality Team. In such cases the referrer will often be advised by ECIRS to complete an EHAP or seek appropriate signposting to universal services from the Family Information Service (FIS).
5. For a small number of cases ECIRS will need to do a brief piece of work to gather more information to assist the screening process.

**MASH (Multi-Agency Safeguarding Hub)**
A multi-agency discussion happens daily and its purpose is to ensure early identification of potential significant harm through information sharing between relevant agencies within 24 hours of a police incident where children are involved. The follow-up action may be referral for early help, a CFA or CP investigation.

Missing young people are also reviewed at a weekly MASH meeting to identify possible safeguarding issues, including sexual exploitation risks. Those in attendance or represented in the MASH meeting are the ECIRS duty manager and senior social worker, a health visitor, the police, Youth Justice and the Probation and Safer Communities Team.

The MASH operates within its own multi-agency information sharing agreement which enables information sharing without consent if the case warrants this.
CFA (Child and Family Assessment)
When a CFA is required in the first instance ECIRS will:

- Discuss the concerns with the referrer and record the discussion
- Review the EHAP provided with the referral
- Clarify if the referrer has parental consent to share information and where appropriate ask the referrer to seek consent (see page 51)
- Consult records already held by Children’s Services
- If the concerns are serious, contact other agencies to gather information
- Within 24 hours advise the referrer what action, if any, will be taken
- Send out an acknowledgement of a referral within three working days
- Send the referrer a letter to let them know what the outcome of the enquiry is. The timing of this letter will depend on the determination of threshold level and response
- The case will then be referred by ECIRS to the relevant SAFE or other Level 3 service as appropriate
- For safeguarding cases a referral will be made to the Children’s Social Care Locality Team.

In urgent situations referral to the locality team will happen before all the above actions have been completed.

Standards of working practice
The following points describe the process once a referral reaches a locality team.

Within three working days the manager and social worker should plan the assessment to include:

- What information is required.
- What issues need to be explored.
- What further information is required from other agencies.
- How detailed the assessment should be.
- By what date it should be completed.

Other points to note:
- It is important that the worker is clear about the purpose of the assessment and shares this with the family. This may require the social worker to speak to the referrer again to clarify or request more detailed information.
- For Child Protection Assessments the social worker should meet the child and family within 24 hours for allegations of physical abuse and neglect and within three working days for allegations of emotional abuse.
- The social worker must inform the family of the concerns raised, the plan for the assessment and seek their agreement to this. For Child in Need assessments this meeting occurs within 10 working days.
- Wherever possible and subject to parental consent, children will be seen on their own to ensure their views and experiences inform the assessment.
- Interpreters will be used for any family where English is not the first language and where there may be difficulty understanding the concerns and any planned actions.
- The manager will set internal review points for the assessment to ensure that it reflects the child’s needs and is completed within timescales.
- Referrers may be called upon to attend strategy meetings, child protection conferences, Child in Need or Team Around the Family (TAF) meetings where necessary.
Assessments can take up to a maximum of 45 working days under existing government guidance, but many will be completed in less time. The assessment period is proportionate to the risk and needs identified.

Once a CFA is completed, the family will be sent a copy of the assessment and the referrer and other agencies involved will be informed of the outcome to the extent that it is appropriate for the Council to share details. There may be occasions when the full detail of a CFA cannot be shared with family members, for example in domestic abuse cases where full disclosure could increase the risk to the children or adult victim.

If it becomes apparent that this timescale will require extension, the first line manager will review the work so far, record the reason for the extension and agree a new timescale. This will only be agreed in exceptional circumstances.

Section 47 (child protection) Investigation

The manager of the Children's Social Care Locality Team, the Hospital Social Work Team or ESCAN can make a decision that the evidence of the case warrants a S47 (child protection) Investigation. In addition to completing a CFA the social worker will:

- Have a strategy discussion or strategy meeting with the police within 24 hours to decide if immediate action to protect the child is necessary and decide if a joint investigation is needed with the police or if the Locality Team will carry out a single agency investigation. Other agencies involved should be included in any discussion/meeting.
- See the child(ren) within 24 hours where there are allegations of physical abuse and neglect.
- See the child(ren) within three days for allegations of emotional abuse especially if the allegation involves domestic violence. Other allegations/cases may require further information to be gathered before seeing the child.
- Have a strategy meeting to address allegations or concerns about child sexual exploitation/sexual abuse, forced marriage, ‘honour’ based violence or female genital mutilation or other forms of gender based abuse or concern about fabricated or induced illness in a child. In these cases it is usually more important to gather relevant information and make a measured, planned decision about when to see the child and/or family.
- Discuss, agree and record any reasons for a delay in seeing the child e.g. to obtain important information or manage the risk resulting from intervention.

If a strategy meeting is convened this should be attended by the police, the referrer, relevant health professionals and school staff as well as the social worker and their manager, who chairs the meeting.

For some complex investigations (e.g. sexual abuse/exploitation/allegations against professionals) the strategy meeting is chaired by a Child Protection Adviser.

When the investigation is complete decisions will be made as to whether the concerns are substantiated or not and whether the child is likely to suffer significant harm. And if so, whether a child protection conference should be convened – this must happen within 15 days of the first strategy discussion/meeting.
SAFE Assessment and Plan
SAFE works with children and families whose needs do not meet the threshold level for referral to a Children’s Social Care Locality Team, i.e. there is no immediate danger or risk to the child and the needs are not complex.

SAFE is a multi-agency and multi-disciplinary service. The service is made up of senior social workers, family support workers, CAMHS workers, domestic abuse specialists, substance misuse workers, counsellors, school and family workers, psychologists, and family therapists. Cases are referred to SAFE following screening by ECIRS for both professional referrals as well as self-referrals.

The SAFE Assessment and Plan shares characteristics and features of both the EHAP and the CFA processes, with minor variations to suit the thresholds of need at which SAFE offers support and intervention.

A SAFE Assessment and Plan is progressed at TAF (Team Around the Family) meetings with the aim of fully including the child and family as with the EHAP. The family share in discussions about their needs and the action plan for support. Where needs are more acute - these are documented using the same level of detail as a CFA.

If safeguarding concerns become apparent or develop during the SAFE Assessment and Plan then the case will be escalated to the relevant Children’s Social Care Locality Team.

Multiple assessments
Being subject to more than one assessment can be stressful for a child and their family and it is very frustrating when different professionals ask for the same information over and over again. This is one of the reasons professionals are now required to have carried out an EHAP for the child and family before making a referral to ECIRS.

It means a single assessment of need has been carried out to engage multi-agency services, lessening the stress and demand on the family to undergo several assessments and giving them a Lead Professional with whom to keep in contact, ask questions etc.

However, specific additional needs of the child may result in the child needing other assessments such as an assessment of special educational needs or health concerns.

To lessen the stress of multiple assessments, professionals are asked to always keep the family informed of what to expect and to explain why another assessment is necessary.

Any professional about to recommend or refer on to a service where a service-specific assessment will be necessary should:

- Ask the family for permission to share information with the professional or service carrying out the other assessment(s) so that information relevant to those assessments doesn’t have to be given by the family more than once
- Be sensitive to the possible stresses on the family and demonstrate empathy and give encouragement
- Where assessments need to be carried out simultaneously - negotiate with professionals completing the other assessment to minimise duplication of information or actions and reduce the risk of appointments at the same or inconvenient times.
Thresholds of need and response

Ealing has developed four levels of need with descriptors for each level to assist practitioners in assessing needs and identifying appropriate responses. The diagram below also shows which assessments are used at each level.

Ealing’s model is similar to those used in other London local authorities to enable a consistent approach to integrated working on a cross-authority basis. It is based on the London Safeguarding Children Board ‘Threshold Document: Continuum of Help and Support’

Level 1: Universal
There are no additional needs. Response services are universal services.

Level 2: Low risk to vulnerable
Children with identified needs, showing early signs of vulnerability or the family’s needs are not clear, not known or not being met. This level is the threshold for initiating an EHAP as the need for early help through multi-agency support is evident. Response services are universal and targeted services.

Level 3: Complex
The family has complex needs that are likely to require longer-term intervention from statutory and/or specialist services. High level additional unmet needs will usually require a targeted and integrated response.

Level 4: Acute
Children are suffering harm or are at risk of harm or abuse and require intensive support and protection. Or the family has acute needs requiring statutory intensive support. This level includes the threshold for child protection requiring Children’s Social Care intervention.
Thresholds of need and response Level 1: Universal

There are no additional needs. Response services are universal services.

Development of unborn baby/child/young person

General health
Good physical health.

Education
Achieving key stages and good attendance.

Physical development
Reaching age appropriate developmental milestones.

Speech, language, communication
Reaching age appropriate developmental milestones.

Emotional and social development
Good mental health and psychological wellbeing. Able to adapt to change and demonstrate empathy and respond appropriately to boundaries and guidance.

Identity, self-esteem, social image and presentation
Positive sense of self and abilities.

Family and social relationships
Good quality early attachments, confident in social situations. Stable families where parents are able to meet the child’s needs. Good relationships with siblings and peers.

Self-care skills and independence
Growing level of competencies in practical and emotional skills e.g. feeding, dressing, developing independent living skills.

Family and environment

Family history and functioning
Stable and supportive family relationships including when parents are separated.

Wider family
Stable and supportive extended family relationships.

Housing
Good quality stable housing.

Family’s social integration
Good social and friendship networks exist within a safe and secure environment.

Community resources
Access to positive activities.

Employment, income and education
Child fully supported financially.
Parents and carers (parenting capacity)

**Basic care**
Parents are able to provide basic needs e.g. food, drink, clothing, medical and dental care.

**Ensuring safety and protection**
Parents ensure the child's safety in the home and elsewhere.

**Emotional warmth and stability**
Parents provide secure and caring parenting meeting the child's needs.

**Guidance and boundaries**
Parents provide appropriate guidance and boundaries to help the child to understand and develop boundaries.

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**Assessment**
No EHAP needed

**Action**
Children can access universal services directly.

**Services** that may provide support at this level:
- Education
- Children’s centres
- Childcare providers
- Health Visiting
- School nursing
- GP
- Midwifery
- Youth & Connexions
- Play Service
- Police
- Housing
- Voluntary & community

For more detailed guidance please see the London Safeguarding Children Board Threshold Document: Continuum of Help and Support at: [http://www.londoncp.co.uk/files/revised_guidance_thresholds.pdf](http://www.londoncp.co.uk/files/revised_guidance_thresholds.pdf)
Thresholds of need and response Level 2: Low risk to vulnerable

Children with identified needs, showing early signs of vulnerability or the family’s needs are not clear, not known or not being met. This level is the threshold for initiating an EHAP as the need for early help through multi-agency support is evident. Response services are universal and targeted services.

Development of unborn baby/child/young person

**General health**
Missed immunisation or health checks. Minor health problems and concerns about diet and hygiene. A child in hospital.

**Education**
Reduced access to books, toys or educational materials. Occasional non-attendance or early indication of truancy. Lower level of attainment, school action/school action plus, NEET, few or no qualifications. Child’s learning is not supported at home.

**Physical development**
Child has some limitations or a disability. Slow reaching developmental milestones.

**Speech, language, communication**
Child has some language and communication difficulties or has SEN. Mild learning difficulties.

**Emotional and social development**
Mild behaviour difficulties emerging, lack of concentration, lack of interest in education or other activities. Low level emotional or mental health issues which require intervention from non-mental health specialists e.g. GP (CAMHS tier 1).

Vulnerable to emotional problems in response to life events such as parental separation or bereavement. Some evidence of inappropriate responses and actions. Difficulties emerging in expressing empathy, understanding, impact of action on others/taking responsibility for actions.

**Identity, self-esteem, social image and presentation**
Low self-esteem and lack of confidence – clingy, anxious or withdrawn. Overfriendly or withdrawn from strangers. Early sexual activity. Experimentation with tobacco, alcohol or drugs.

**Family and social relationships**
Ongoing difficulties with peer group, family or other adult relationships. Victim or perpetrator of bullying or discrimination. Parent has physical or mental health difficulties.

**Self-care skills and independence**
Lack of age-appropriate behaviour and independent living skills that increase vulnerability to social exclusion.

Family and environment

**Family history and functioning**
Parents have some conflict or difficulties that involve the child.

**Housing**
Overcrowded, poor quality housing.
Community resources
Insufficient facilities to meet needs e.g. transport or access issues. Family require advice regarding social exclusion. Limited support/family new to the area.

Employment, income and education
Low income and unemployment.

Parents and carers (parenting capacity)

Basic care
Concerns about parenting capacity identified before a child is born (e.g. due to substance misuse, domestic violence and abuse, mental health issues). Early signs of abuse or early patterns of neglect identified.

Ensuring safety and protection
Physical care or supervision of child is inadequate. Parental learning disability, parental substance misuse, or mental health impacting on parent’s ability to meet the needs of the child.

Emotional warmth and stability
Inconsistent parenting but child development not significantly impaired.

Guidance and boundaries
Inconsistent care e.g. inappropriate childcare arrangements or young inexperienced parents. Lack of routine in the home. Lack of response to concerns raised by practitioners about the child. Child has limited access to leisure activities/spends considerable time alone e.g. watching television.

Parents have asked for support to manage their child’s behaviour.

Assessment
EHAP

Action
Use the EHAP for a multi-agency/multi-disciplinary approach to delivering early help before needs become more complex and acute.

If needs change or the EHAP identifies the need for intervention by additional specialist or targeted services such as SAFE, contact ECIRS for advice and to make a referral.

Practitioners will be required to have conducted an EHAP and to provide basic identifying details of the child and family.

Children’s Social Care would not be involved at this level.

Services that may provide support at this level:

- SAFE
- Educational Psychology
- Primary Behaviour Service
- Educational Welfare
- Mental health and substance misuse services
- Extended school provision
- Children’s centres
- Childcare providers
- Health Visiting
- School nursing
- GP
- Midwifery
- Youth Justice Service
- Youth & Connexions
- Play Service
- Police
- Housing
- Voluntary & community

For more detailed guidance please see the London Safeguarding Children Board Threshold Document: Continuum of Help and Support at: http://www.londoncp.co.uk/files/revised_guidance_thresholds.pdf
Thresholds of need and response Level 3: Complex

The family has complex needs that are likely to require longer-term intervention from statutory and/or specialist services. High level additional unmet needs will usually require a targeted and integrated response.

Development of unborn baby/child/young person

**General health**
Disability requiring specialist support to remain in mainstream setting. Concerns about weight/diet and dental decay. Child has chronic health problems not treated or badly managed, missed appointments.

Unsafe sexual activity, teenage pregnancy/smokes/uses illegal substances.

Eating disorder e.g. anorexia or bulimia.

Mental health issues emerging requiring specialist intervention in the community e.g. conduct disorder; ADHD; anxiety; depression; eating disorder; self-harming; schizophrenia, bipolar, post traumatic or obsessive compulsive disorders/terminal or long-term illness.

**Education**
Persistent late/non-attendance at childcare or school. Poor or no home/school links. No parental support for education. Short-term exclusion or risk of permanent exclusion, persistent truanting or no education provision. Little or no improvement in achieving targets despite additional support.

**Physical development**
Development milestones are unlikely to be met.

**Speech, language, communication**
Statement of Special Educational Needs.

**Emotional and social development**
Very limited interests/no access to books, toys or educational materials/limited participation of child in education or training. Finds it difficult to cope with or express emotions appropriately. Significant difficulties with managing change, dealing with a loss or trauma (i.e. bereavement).

Disruptive/challenging/high risk behaviour at school, home or in the neighbourhood with is unresponsive to Level 1 and 2 interventions e.g. running away, increased frequency and patterns of missing from home or school, underage sexual activity, drug use. Such behaviours increase the risk of child being sexually exploited.

Risk of radicalisation or involvement in extremism.

Lack of empathy and understanding of impact of actions on others. Aggressive behaviour/appearance and may be bullying others.

Starting to commit offences/re-offend or be a victim of crime.

**Identity, self-esteem, social image and presentation**
Concern about quality and frequency of social interaction, language, understanding and expressive language development. Appears regularly anxious, stressed or phobic.

Very low self-esteem. Presentation significantly impacts on all relationships/is watchful or wary of carers/people.

Subject to persistent discrimination e.g. racial, sexual, homophobic or discrimination due to illness or disability.
Family and social relationships
Family relationships or those with other adults are a cause for concern. Significantly poor relationships with peers/difficulty sustaining relationships/issues of attachment/isolation.

Self-care skills and independence
Lack of age appropriate independent living skills, likely to impair development or lead to alienation from peers. Disability prevents self-care in a significant range of tasks. Lacks a sense of safety and often puts themselves in danger.

Family and environment

Family history and functioning
History of domestic violence including acrimonious divorce/separation impacting on the child. Risk of relationship breakdown between parent and child. Persistent relationship difficulties with siblings.

Child is a young carer to a parent with a disability, substance misuse issues or mental health issues.

Child has a parent in prison.

Privately fostered children – Section 17 criteria is met by definition.

Historical periods of child and/or sibling being accommodated by the Local Authority.

Wider family
Family has poor relationship with extended family/no support network.

Housing
Housing conditions impacting directly on welfare of children. Children are experiencing frequent moves and instability. Parents have been assessed as intentionally homeless/homeless unaccompanied minors – Section 17 criteria is met.

Employment, income and education
Extreme poverty impacting directly on welfare of children.

Parents and carers (parenting capacity)

Basic care
Parental learning disability, substance misuse, mental health or lifestyle impacting on parent’s ability to meet the needs of the child.

Ensuring safety and protection
Physical care or supervision of child is inadequate. Incidence of serious and/or persistent violence in the family increasing in severity/frequency, history of previous assaults. Parents use physical discipline or other harsh method.

Emotional warmth and stability
Relationship with parents characterised by inconsistency/lack of stimulation/poor interaction/lack of positive role models. Child has multiple carers; may have no significant or positive relationship with any of them/child has no other positive relationships.

Guidance and boundaries
Parental non-compliance and disengagement. Parent provides inconsistent boundaries or responses. Child is missing but not reported missing by parent. Parent indifferent to smoking, underage drinking, drug use and early sexual relationships.

Assessment
EHAP

Action
Refer to ECIRS.

An EHAP will be required to demonstrate early help delivered and results to better inform a referral to ECIRS so that the most appropriate next step can be taken.

A referral to ECIRS may result in a response by Level 3 services or in the case of a safeguarding concern, be escalated to Level 4 Children’s Social Care.

Appropriate Level 3 services such as SAFE will work with the family either alone or within a multi-agency/multi-disciplinary response to the family’s needs.

Where Children’s Social Care becomes involved a CFA (Child & Family Assessment) will be undertaken by a social worker, leading to a Child in Need Plan.

Other referrals
Referrals can be made to the Primary Behaviour Service from mainstream schools following agreement with an Educational Psychologist or through an SEN panel.

For more detailed guidance please see the London Safeguarding Children Board Threshold Document: Continuum of Help and Support at: http://www.londoncp.co.uk/files/revised_guidance_thresholds.pdf
Thresholds of need and response Level 4: Acute

Children are suffering harm or are at risk of harm or abuse and require intensive support and protection. Or the family has acute needs requiring statutory intensive support. This level includes the threshold for child protection requiring Children’s Social Care intervention.

Development of unborn baby/child/young person

General health
High level disability which cannot be maintained in a mainstream setting. Serious physical and emotional health problems requiring specialist intervention including in-patient treatment. Refusing medical care, placing child’s health and development at significant risk.

Persistent and high risk substance misuse/dangerous sexual activity and/or early teenage pregnancy/sexual exploitation/sexual abuse or self-harming.

Child is suspected to have suffered or be at risk of Female Genital Mutilation (FGM)

Education
Chronic non-attendance, truanting/no parental support for education. Significant periods of missing from school. Permanently excluded, frequent exclusions or no education provision.

Speech, language, communication
Severe and complex learning difficulties requiring residential educational provision.

Emotional and social development
Subject to or at risk of physical, emotional or sexual abuse or neglect. Severe emotional/behavioural challenges resulting in serious risk to the child and others. Goes missing from home and is engaging in risky behaviours. Concern they may be being sexually exploited. Child is suspected of being groomed to or is already engaging in radical & extremist activities or may be at risk of travel to a conflict zone.

Family and social relationships
Children who need to be looked after outside of their family.

Self-care skills and independence
Severe lack of age appropriate independent living skills likely to result in significant harm e.g. bullying, isolation, inappropriate self-presentation.

Family and environment

Family history and functioning
High levels of domestic violence that put the child directly at risk. History of risk due to parent’s prior actions in relation to siblings.

Housing
No fixed abode or homeless/imminently homeless/housing conditions posing serious risk to welfare.
Parents and carers (parenting capacity)

**Basic care**
Parents are unable to care for the child. Suspicion of long-term neglect e.g. if the child is hungry, has ill-fitting or dirty clothes, child looks dirty, parent speaks harshly of the child without warmth or empathy, no stimulation is provided such as toys or activities.

**Ensuring safety and protection**
Suspicion of physical, emotional, sexual abuse or neglect. Parents are believed to have caused physical injury to the child. Parents involved in crime or who are unable to restrict access to home by dangerous adults.

**Emotional warmth and stability**
Parent’s mental health problems or substance misuse places the child’s development at significant risk. Evidence of emotionally abusive relationships placing the child’s development at significant risk.

**Guidance and boundaries**
Parents unable to provide satisfactory parenting which puts the child’s development at significant risk. Little or no improvement in parenting capacity despite professional interventions. Serious anti-social behaviour within the local community. Child beyond parental control/is offending/or has no one to look after them. Frequent periods of missing from home which are not reported by the parent.

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**Assessment**
EHAP (except for urgent child protection referrals)
A CFA will be conducted by Children’s Social Care once a referral is made.

**Action**
If there is a concern that a child has been harmed or is at risk of immediate harm, call ECIRS on 020 8825 8000 (24hrs) for referral to one of the six Children’s Social Care locality teams who will decide what immediate action to take to safeguard the child.

ECIRS will also refer to the locality teams children in need who require a Child and Family Assessment (CFA) where there are some safeguarding concerns but no need for immediate action. Schools following agreement with an Educational Psychologist or through an SEN panel.

For cases where children and young people face the possibility of going into care, a referral will be made to the Multi Agency Support Team (MAST) for intensive support for the child/young person and their family to try to prevent this from being necessary.

For more detailed guidance please see the London Safeguarding Children Board Threshold Document: Continuum of Help and Support at: http://www.londoncp.co.uk/files/revised_guidance_thresholds.pdf
Ealing CAMHS Threshold Guide

The levels indicated are NOT absolute thresholds and are NOT an exhaustive list of conditions. In addition it is not an exhaustive list of providers. They are a guide to assessment and appropriate intervention.

<table>
<thead>
<tr>
<th>PROBLEM CATEGORY</th>
<th>EALING TIER 2</th>
<th>EALING TIER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Low Mood</td>
<td>Early evidence of mood disorders</td>
<td>Serious indicators of depression</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>Early evidence of deliberate self-harming behaviour, including suicidal ideas that are not intended to be acted on</td>
<td>Suicide attempt, suicidal ideation, repeated self-harm</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Emotional problems related to eating e.g. fussy eating</td>
<td>Weight loss, Anorexic behaviour, Bulimic pattern</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Early onset of anxiety disorders including phobias, mild Obsessive Compulsive Disorder (OCD) symptoms</td>
<td>Significant anxiety, especially OCD and severe/entrenched phobias</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>Concern about attention span</td>
<td>Assessment for ADHD, and treatment of ADHD</td>
</tr>
<tr>
<td>Behaviour Problems</td>
<td>Behaviour management problems, parent training</td>
<td>Not as sole reason for referral: Behaviour problems when part of complex set of problems or to assess for possible other conditions</td>
</tr>
<tr>
<td>Anger Problems</td>
<td>Anger management problems</td>
<td>Not as sole reason for referral: seen when anger is part of complex picture or to assess possible other conditions</td>
</tr>
<tr>
<td>Sleep Problems</td>
<td>Sleep problems</td>
<td>Not as sole reason for referral: seen when sleep problems are part of complex picture or to assess possible other conditions</td>
</tr>
<tr>
<td>Low Self-Esteem</td>
<td>Self-esteem issues</td>
<td>Not as sole reason for referral: seen when as part of complex picture or to assess for other conditions</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Substance use / misuse – referrals made through Ealing Children’s Integrated Response Service</td>
<td>Young person experiencing problematic drug / alcohol misuse related issues – referrals to be made directly to the EASY project using the DUST form</td>
</tr>
<tr>
<td>Enuresis and Encopresis (Bedwetting and Soiling)</td>
<td>Issues related to Encopresis and Enuresis following paediatric assessment</td>
<td>Not as sole reason for referral: seen when enuresis is part of complex picture or to assess possible other conditions</td>
</tr>
<tr>
<td>Bereavement, Loss and Trauma</td>
<td>Early negative consequence from loss, bereavement, transition and abuse</td>
<td>For pathological grief reactions, Post Traumatic Stress Disorder, serious and sustained reactions to life events</td>
</tr>
<tr>
<td>Divorce and Separation</td>
<td>Low impact mental health difficulties e.g. reaction to separation / divorce</td>
<td>Not unless the reactions indicate a mental health disorder</td>
</tr>
<tr>
<td>School-Based Problems</td>
<td>School focused concerns about mental health issues related to a child if other relevant support agencies not involved</td>
<td>Not unless there is clear evidence of, or need for assessment for a specified mental health problems</td>
</tr>
<tr>
<td>Severe Learning Difficulties</td>
<td>Where there are concerns about possible emotional, behavioural or mental health problems (ESCAN)</td>
<td>Children with severe learning difficulties where there are concerns about complex mental health problems</td>
</tr>
<tr>
<td>School Refusal</td>
<td>School refusal where early evidence of a potential mental health issue has been identified and education support services have been involved</td>
<td>Not unless there is evidence of, or need for assessment for a specific mental health problem</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Not appropriate here</td>
<td>Assessment and treatment of all psychotic disorders</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder (ASD)</td>
<td>Children with ASD have the right to the same range of services as the rest of the population – above Tier 2 Thresholds apply</td>
<td>Assessment of children for autistic spectrum disorders, including concerns about co-morbid mental health problems</td>
</tr>
</tbody>
</table>
Introduction
The Domestic Violence Risk Assessment Matrix, produced by Barnardos (p41-43) can help practitioners to use the available information for each case in making a judgement about the risk of harm to a child.

Practitioners who have not had specific training should, wherever possible, complete the risk identification matrix together with their agency’s nominated safeguarding children adviser.

A practitioner may have a lot or very little information indicating that domestic violence is taking place within a family. The practitioner should look across the whole matrix and tick the description/s of the incidents/circumstances which correspond best to the information available at the time. This is likely to mean ticking several descriptions.

The scale headings at the top of each section indicate the degree of seriousness of each cluster of incidents/circumstances (e.g. scale 1: moderate risk of harm).

Each scale has categories to assist practitioners to think through whether the information is about the:

- **Evidence of domestic violence**: This is the most significant determinant of the scale of risk (moderate through to severe)
- **Characteristics of the child or situation which are additional ‘risk factors/potential vulnerabilities’**: These are the factors that may increase the risk of children suffering significant harm through the domestic violence
- **Characteristics of the child or situation which are ‘protective factors’**: Practitioners should keep in mind that protective factors may help to mitigate risk factors and potential vulnerabilities.

A family’s situation may mean that there are ticks under more than one scale heading e.g. moderate (scale 1) and moderate to serious (scale 2). Where this is the case, practitioners should judge the risk to the child/ren to be at the higher level (in this case, scale 2) and plan accordingly.

**Practitioners should always keep in mind the possibility that a piece of information, currently not known, could significantly raise the threshold of risk for a child.**
Domestic violence threshold measures

Scale 1: moderate risk of harm to the child/ren identified
A child assessed at this level will have additional needs that may be addressed with the support of a single service or agency or through a multi-agency approach and use of an EHAP.

If an EHAP is initiated, the action plan must include planning for the safety of the child/ren and mother. And referral of the abuser to an appropriate perpetrator programme.

These actions must then be followed up.

Scale 2: moderate to serious risk of harm to the child/ren identified
A child assessed at this level will have additional needs that require a multi-agency approach and therefore an EHAP to be initiated.

Scale 3: safeguarding, serious risk of harm to the child/ren identified
In threshold scale 3, protection factors are limited and the children may be suffering or be at risk of suffering significant harm. Intervention and support for the child/ren and their mother will require local authority children's social care planning, using a Section 17 children in need assessment.

In Ealing, a referral should be made to ECIRS who will refer the case to the Children's Social Care Locality Team for a Child and Family Assessment under Section 17 of the Children Act 1989.

This may escalate to a child protection investigation under Section 47 of the Children Act 1989.

Scale 4: initiate child protection procedures, severe risk of harm to the child/ren identified
Threshold scale 4 assesses the domestic violence as severe with increased concern regarding children's wellbeing due to additional contributory risk factors. In threshold scale 4, protective factors are extremely limited and the threshold of significant harm is reached.

A referral should be made to ECIRS and followed up in writing. ECIRS will refer the case to the Children’s Social Care Locality Team who will carry out a child protection investigation under Section 47 of the Children Act 1989 and if necessary a child protection conference.

All actions and contacts with the children, mother and the abuser including information given and received should be recorded thoroughly.

For more guidance, refer to the London Safeguarding Children Board's Safeguarding Children Abused through Domestic Violence guidance, available at www.londoncp.co.uk/chapters/sg_ch_dom_abuse.html
Domestic Violence Risk Assessment Matrix

### DVRIM: Level of risk Moderate Scale 1.
### CAF: Level 2 Threshold of need child with additional needs.

Children & families with additional needs.

CAF completed - Single Practitioner targeted support – Children under 7yrs/with special needs increases risks. The younger the child/ren the higher the risk to their safety. Consider protective factors.

<table>
<thead>
<tr>
<th>Evidence of Domestic Violence</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 minor incidents of physical violence which were short in duration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim did not seek medical treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intense verbal abuse.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk factors/ Potential vulnerabilities</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/ren were not drawn into incidents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control by abuser is not intense.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/mother relationship is nurturing, protective and stable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant other in child’s life - positive and nurturing relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of child/ren was a restraint for the abuser.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser accepts responsibility for abuse and violence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser indicates genuine remorse and is willing to seek support for abusive behaviour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim has positive support from family/ friends &amp; community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim appears emotionally strong (not worn-down by the abuse).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim sought appropriate support and/or is willing to accept help from other agencies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BME (Black, Minority, Ethnic) Issues: Across all scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask yourself the following questions: If this parent…</td>
</tr>
<tr>
<td>1 Cannot speak, read or write English</td>
</tr>
<tr>
<td>2 Fears that the ‘State’ is authoritarian</td>
</tr>
<tr>
<td>3 Lacks strong social networks</td>
</tr>
<tr>
<td>4 Lives in temporary housing</td>
</tr>
<tr>
<td>5 Is living below the poverty line</td>
</tr>
<tr>
<td>6 Has a child who is of a different appearance and culture to them</td>
</tr>
<tr>
<td>7 Is living in a close-knit community in London</td>
</tr>
<tr>
<td>8 Has a perspective on parenting practices underpinned by culture or faith which are not in line with UK law &amp; cultural norms</td>
</tr>
<tr>
<td>9 Recognises his/her faith or community leader as all powerful</td>
</tr>
<tr>
<td>10 Puts a very high value on preserving family honour and, if this young person…</td>
</tr>
<tr>
<td>11 Is compromised in relation to his/her community</td>
</tr>
<tr>
<td>12 Has strong allegiance to a group or gang</td>
</tr>
</tbody>
</table>

If you need further information, please refer to the BME checklist, downloadable from the LSCB website.

### DVRIM: Level of risk Moderate to Serious Scale 2.
### CAF: Level 2 Threshold of need child with additional needs.

Children & families with additional needs. CAF completed – Lead professional-integrated support Child/ren under 7yrs/with special needs - at higher risk of emotional/physical harm – limited self-protection strategies - can raise threshold to Scale 3. Consider protective factors.

<table>
<thead>
<tr>
<th>Evidence of Domestic Violence</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of minor/moderate incidents of physical violence - short duration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim received minor injuries - medical attention not sought.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of intimidation/bullying behaviour - pushing / finger poking / shaving / to victim but not towards child/ren - Destruction of property.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intense verbal abuse-consistent use of derogatory language.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of isolation - Abuser attempts to control victims’ activities, movements &amp; contact with others.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk factors/ Potential vulnerabilities</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/ren were present in the home during an incident but did not directly witness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential likelihood of emotional abuse of children.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BME (Black, Minority, Ethnic) Issues: See Grey Box.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability issues within family - positive support networks.</td>
</tr>
<tr>
<td>Mental health issues - not prolonged or serious. Abuser or victim seeking appropriate help.</td>
</tr>
<tr>
<td>Age of abuser and/or Victim - both have supportive resources and are not isolated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/mother relationship is nurturing, protective &amp; stable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In spite of abuse, victim was not prevented from seeing to the needs of her child/ren.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant other in child’s life - positive and nurturing relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older child/ren use coping/ protective strategies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim attempted to use protective strategies with older child/ren.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim is prepared to take advice on safety issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim has insight into the risks to her child/ren posed by the abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim has positive support from family/friends and community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser willing to engage in services to address his abusive behaviour.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DVRIM: Level of risk Serious Scale 3.
CAF: Level 3 Threshold of need child with complex needs.

Child/ren in Need - Children’s Services may consider Section 17 but Safeguarding intervention may be necessary if threshold of significant harm is reached. Professional case planning Child/ren aged under 7yr/for child/ren with special needs can raise threshold to scale 4

<table>
<thead>
<tr>
<th>Evidence of Domestic Violence</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident(s) of serious and/or persistent physical violence in family. Increasing in severity/frequency and/or duration - History of previous assaults.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim and/or children indicate that they are frightened of abuser - put in fear by looks, actions, gestures and destruction of property (emotional &amp; psychological abuse).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent separation - repeated separation/reconciliation/ongoing couple conflict.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stalking/harassment of mother/children - Increased risk of isolation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse through the use of texting/social networking sites.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser breaching bail conditions/civil protective orders / non-contact orders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim required medical treatment but not sought /or explanation for injuries implausible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurring or frequent requests for police intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident(s) of violence occur in presence of child/ren - consider duration of exposure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats of harm to mother/and or children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive jealousy/possessiveness of abuser - domineering in relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial control maintained by abuser.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser has history of domestic violence in previous relationships.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk factors/ Potential vulnerabilities</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health issues - abuser and/or victim-rises concern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse by abuser and/or victim-rises concern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser’s and/or victim’s infidelity is a source of conflict/anger.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong likelihood of emotional abuse of child/ren - may display behavioural problems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/ren unable to activate safety strategies due to fear or intense control by abuser.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of safe significant other as a positive support to child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child contact issues - domestic abuse occurring at contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older children /Adolescent - increased risk of intervening in abuse and emerging concerns re self harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser suspected of using physical abuse towards child/ren.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser shows lack of insight/empathy into how his behaviour effects children/victim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser’s minimisation of abuse-lack of remorse /guilt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser is Boyfriend/Father figure. Family unit has step-siblings.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Abuser’s abuse of pets/animals/used to intimidate. | | |
| Emerging concerns about emotional stability of abuser’s relationship with child/ren / limited parenting capacity & lack of protective abilities. | | |
| Emerging concerns about emotional stability of child/mother relationship (parenting capacity and protective concerns). | | |
| Emerging concerns of neglect of child/ren’s emotional and physical needs-missed health appointments/poor living conditions. | | |
| Abuser’s use of avoidance/resistance to engage in services increases risk level to children. | | |
| Victim fears statutory services - avoidance & resistance to engage increases risk to children. | | |
| Family/relatives/neighbours reports concerns re victim/children. | | |
| Victim has experienced domestic violence in previous relationships. | | |

<table>
<thead>
<tr>
<th>BME (Black, Minority, Ethnic) Issues: See Grey Box.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult learning difficulties-abuser and/or victim-raises concern.</td>
</tr>
<tr>
<td>Disability issues within family - isolation.</td>
</tr>
<tr>
<td>Age disparities of Abuser/Victim - under 25 with limited support with personal vulnerabilities.</td>
</tr>
<tr>
<td>History of childhood abuse/disruptive childhood experiences - abuser and/or victim.</td>
</tr>
<tr>
<td>Collusion issues present in extended families/friends - not supportive for victim/children.</td>
</tr>
<tr>
<td>Recent life crises/stress factors - i.e unemployment, financial problems, illness, death.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older child/ren use protective strategies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim will seek positive support from significant other.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim - attempts to use protective strategies but abuser’s violence &amp; control is intense.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim will engage with supportive services and seek safety advice - be alert to abuser’s control interfering with her level of commitment to engage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited protective factors are present - serious level of violence and psychological abuse of victim, emotional abuse of child/ren and Domestic Violence risk factors predict recidivism.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of kinship placements as a protective factor - be alert to domestic violence having occurred or occurring in extended families.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Y = Yes  S = Suspected
**Evidence of Domestic Violence**

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated serious and/or severe physical violence - life threatening violence. Attention to the frequency, duration and severity of violent behaviour children exposed to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use/assault with weapons.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser's violation of protective and/or child contact orders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criminal history of abuser, gangland connections, generalised aggression, history of anti-social behaviour, aggression towards previous partners/family members, military service/training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intense stalking/harassment behaviour of abuser - increased risk of isolation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurring or frequent requests for police intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim requires treatment for injuries sustained - Medical attention required but not sought or injuries explanation is implausible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats to kill or seriously injure victim and/or children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim is very frightened of abuser - believes intent of threats - Retaliatory violence a concern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim is intensively controlled/may present as submissive - worn down by abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim is pregnant/victim is abused in post natal period/recently separated with new baby raises risk level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed emotional/psychological/abuse of mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual assault/suspected sexual abuse of victim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidences of violence witnessed &amp; occurred in presence of children - distressed/aftermath of incident. Children have directly intervened in incidences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/ren summon help/discloses-immediate heightened risk to this child of being ‘punished’/adverse reaction from abuser and/or mother-assess adult’s reaction to child’s disclosure. Child/ren may disclose another form of abuse to draw attention to the situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/ren have been physically assaulted/abused.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed emotional abuse of child/ren.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected/confirmed sexual abuse of child/ren.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuser is a perpetrator of child abuse but may not have been prosecuted. Known to MAPPA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim has been identified by DASH-MARAC process as high risk.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk factors/ Potential vulnerabilities**

<table>
<thead>
<tr>
<th>Vulnerabilities</th>
<th>Y</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health issues - abuser and/or victim - raises significant concern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse by abuser and/or victim - raises significant concern.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Protective factors:**

Believe in children

Barnardo’s
London, East and South East
www.barnardos.org.uk

**Abuser’s and/or victim’s infidelity is a source of conflict/anger - Victim’s infidelity gives rise to risk of severe reactive violent response from abusive partner-extreme jealousy/possessiveness. Concerns of neglect of children’s emotional and physical needs/poor living conditions.**

**Substantial risk of repeated serious domestic violence.**

**Threats or attempts to abduct children.**

**Children exhibit sexualised behaviour and/or sexually harmful behaviour.**

**Adolescent - increased risk of intervening in abuse and self harm-emerging concerns re mental health issues.**

**Child/ren in family has previous care history. Physical abuse of child/ren by abuser and/or victim.**

**Victim uses physical abuse on children as an alternative to harsher physical abuse by abuser.**

**Recent suicidal or homicidal ideation/intent by abuser.**

**Victim suicidal/attempted suicide/self harming - especially BME victims.**

**Victim minimising risks to children/remains in abusive relationship, protection orders not sought, or activated.**

**Victim/child has poor general health.**

**Abuser shows lack of empathy/insight into how his abusive behaviour is affecting child/victim.**

**Abuser’s minimisation of abuse-lack of remorse/guilt.**

**BME (Black, Minority, Ethnic) Issues:**

See Grey Box.

**Age disparities - Abuser and/or victim under 25 with limited support with personal vulnerabilities.**

**Collusion issues present in extended families/friends - not supportive for victim and children.**

**History of childhood abuse/disruptive childhood experiences abuser and/or victim.**

**Abuser uses threatening aggressive behaviour towards professionals.**

**Agencies unable to work constructively with family ‘Assessment Paralysis’.**

**Abuser/victim use of avoidance/resistance to engage - misuse of complaints procedures.**

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Ealing’s Child Sexual Exploitation (CSE) Risk Assessment Matrix

Ealing’s CSE Risk Assessment Matrix was developed to help professionals to better assess a child or young person who they have a concern for, in relation to CSE. This toolkit should be used in conjunction with Child Protection Procedures where appropriate: www.londoncp.org.uk

Vulnerability factors
The first stage of assessment is to identify vulnerability factors. These are often what makes a young person susceptible to exploitation or places them in vulnerable situations or circumstances. When identifying these factors, you will need to (in parallel) identify any additional risk indicators as outlined in the matrix; remembering that these indicators are intended as a guide and not an exhaustive and absolute list - professional judgement should be used at all times.

Risk Indicators
Once you have worked your way through the CSE Risk Assessment Matrix (pages 47 - 49), your findings will inform any assessment and planning for the child/young person at risk of exploitation. The matrix outlines indicators of low, medium or high level risk of harm from sexual exploitation. This information allows the CSE & Missing Coordinator to consider threshold levels and appropriate intervention.
### Step 1 & 2: Identify Vulnerability Factors / Risk Indicators

#### Vulnerability Factors (tick all that apply)

<table>
<thead>
<tr>
<th>Vulnerability Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in a chaotic or dysfunctional household (including parental substance use,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>domestic violence, parental mental health issues, parental criminality)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of abuse (including familial child sexual abuse, risk of forced marriage,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>risk of ‘honour’ based violence, physical and emotional abuse and neglect)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent bereavement or loss</td>
<td></td>
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</tr>
<tr>
<td>Gang association either through relatives, peers or intimate relationships (in cases of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gang associated CSE only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending school with young people who are sexually exploited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure about their sexual orientation or unable to disclose sexual orientation to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>their families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends with young people who are sexually exploited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless / sofa surfing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living in a gang neighbourhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living in residential care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living in hostel, bed and breakfast accommodation or a foyer</td>
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<td></td>
</tr>
<tr>
<td>Low self-esteem or self-confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young carer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Risk Indicators (tick all that apply)

<table>
<thead>
<tr>
<th>Risk Indicator</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing from home or care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or alcohol misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement in offending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat sexually-transmitted infections, pregnancy and terminations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent from school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in physical appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of sexual bullying and / or vulnerability through the internet and / or social networking sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipt of gifts from unknown sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruiting others into exploitative situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of or attempts at suicide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step 3: Complete the CSE Risk Factors Matrix

### Risk Level 1 / Low

Low risk cases do not usually meet the threshold for Social Care intervention but should have individual or multi-agency intervention through an EHAP.

### Number of Indicators

One or more risk indicators identified

### Behaviours

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>✔️</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly coming home late or going missing</td>
<td></td>
</tr>
<tr>
<td>Overt sexualised dress</td>
<td></td>
</tr>
<tr>
<td>Sexualised risk taking including on the internet (such as sharing compromising images)</td>
<td></td>
</tr>
<tr>
<td>Unaccounted for monies or goods</td>
<td></td>
</tr>
<tr>
<td>Associating with unknown adults or other sexually exploited children</td>
<td></td>
</tr>
<tr>
<td>Reduced contact with family / friends</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td></td>
</tr>
<tr>
<td>Experimenting with drugs / alcohol</td>
<td></td>
</tr>
<tr>
<td>Poor self image, eating disorder, some self-harm</td>
<td></td>
</tr>
</tbody>
</table>

### Required Action Checklist

- Discuss with manager / NSP
- Contact CSE & Missing Coordinator
- Return interview (if missing)
- EHAP
- Notify MISPER Police if the child or young person is going missing
- Keep detailed records of incidents / risks
- Keep chronologies

### Considerations

No child under 13 can be categorised as LOW.
No child or young person with a learning disability can be categorised as LOW.
## ESCB CSE Assessment Matrix

### Risk Level 2 / Medium

In relation to the medium level indicators, should professional judgement determine that there is reasonable cause to suspect that the child is suffering or likely to suffer significant harm requiring investigation under S47 of the Children Act, then the procedures detailed under the higher level of risk should be followed.

### Number of Indicators

Any of the above AND ONE OR MORE INDICATORS IDENTIFIED

### Behaviours

<table>
<thead>
<tr>
<th>Behaviours</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting into cars with unknown adults</td>
<td>✓</td>
</tr>
<tr>
<td>Relationships developed on the internet that could involve grooming</td>
<td></td>
</tr>
<tr>
<td>Disclosure of physical / sexual assault with no substantiating evidence to warrant a S47 enquiry, followed by withdrawal of complaint</td>
<td></td>
</tr>
<tr>
<td>Reports of involvement in CSE such as being seen in known 'hot spots'</td>
<td></td>
</tr>
<tr>
<td>Older boyfriend / girlfriend</td>
<td></td>
</tr>
<tr>
<td>Persistent truancy and risk of exclusion or having been excluded</td>
<td></td>
</tr>
<tr>
<td>Staying out overnight with no explanation</td>
<td></td>
</tr>
<tr>
<td>Breakdown of placements due to behaviour</td>
<td></td>
</tr>
<tr>
<td>Unaccounted monies or goods i.e. mobiles, drugs, alcohol, clothing</td>
<td></td>
</tr>
<tr>
<td>Self-harm requiring medical assistance</td>
<td></td>
</tr>
<tr>
<td>Multiple sexually transmitted infections</td>
<td></td>
</tr>
<tr>
<td>Repeat offending</td>
<td></td>
</tr>
<tr>
<td>Gang association or membership</td>
<td></td>
</tr>
</tbody>
</table>

### Required Action Checklist

As before for low risk level plus:
- Referral into ECIRS (if not an allocated case)
- Strategy meeting
- Refer to MASE
- If not S47, EHAP to be completed within 10 working days
- Police discussion regarding investigation needs / MISPER

### Considerations

Where a child / young person is considered to be at risk or likely to be at risk of significant harm or if the NSP is not available, a referral must be made immediately to ECIRS.
### Risk Level 3 / High

It is envisaged that the use of an Initial Child Protection Conference (ICPC) in cases of sexual exploitation will be relatively rare, but will take place where there are a number of other concerns alongside the sexual exploitation, in particular neglectful or collusive parenting. Where sexual exploitation remains the critical issue, the CSE & Missing Coordinator will chair the ICPC. Where the other issues indicate significant harm, but sexual exploitation is not the primary risk factor, the case will be passed to a Child Protection Adviser.

### Number of Indicators

Any of the above AND ONE OR MORE INDICATORS IDENTIFIED

#### Behaviours

<table>
<thead>
<tr>
<th></th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child under 13 engaging in sexual activity</td>
<td></td>
</tr>
<tr>
<td>Pattern of street homelessness and staying with an adult believed to be sexually exploiting them</td>
<td></td>
</tr>
<tr>
<td>Child under 16 meeting different adults for sex</td>
<td></td>
</tr>
<tr>
<td>Removed from red light districts by professionals due to CSE</td>
<td></td>
</tr>
<tr>
<td>Being taken to clubs / hotels for sex with adults</td>
<td></td>
</tr>
<tr>
<td>Disclosure of sexual assault and then withdrawal of disclosure / statement</td>
<td></td>
</tr>
<tr>
<td>Abduction and forced imprisonment</td>
<td></td>
</tr>
<tr>
<td>Disappearing from the system with no contact or support</td>
<td></td>
</tr>
<tr>
<td>Being bought / sold / trafficked</td>
<td></td>
</tr>
<tr>
<td>Under 16 with multiple miscarriages and terminations</td>
<td></td>
</tr>
<tr>
<td>Indicators of CSE in conjunction with chronic alcohol and drug use</td>
<td></td>
</tr>
<tr>
<td>Indicators of CSE alongside serious self-harming</td>
<td></td>
</tr>
<tr>
<td>Receiving a reward for recruiting other peers to CSE</td>
<td></td>
</tr>
</tbody>
</table>

#### Required Action Checklist

- [ ] Discuss with manager/NSP
- [ ] Contact CSE & Missing Coordinator
- [ ] Referral into ECIRS (if not an allocated case)
- [ ] Strategy / CP conference
- [ ] Refer to MASE
- [ ] Ensure information is recorded
- [ ] Use chronologies

#### Considerations

Where a child / young person is considered to be at risk or likely to be at risk of significant harm or if the NSP is not available, a referral must be made immediately to ECIRS.
ESCB CSE risk assessment toolkit work flow

Professional has concerns a child / young person is at risk of sexual exploitation

Identify the vulnerability factors / risk indicators – Using the matrix

Discuss with CSE & Missing Coordinator – to establish appropriate intervention

Use the CSE risk indicators to determine level of risk

Thresholds / intervention / outcomes

Low Risk
All level 1 cases should be discussed with the CSE & Missing Coordinator to agree level of risk and appropriate intervention. Most cases at level 1 will be managed via Child In Need framework. In cases where a young person has been assessed as being at level 1 risk - multiagency or professionals meetings can be chaired by the CSE Coordinator or the line manager from the allocated team. A plan of intervention should be drawn up at this meeting and implemented by the allocated social worker and / or team. These cases should not be referred to MASE Panel.

Medium Risk
Level 2 cases would in general indicate the risk of significant harm and should therefore be managed as any other child protection case. A multi-agency strategy meeting, to include all key professionals, should be held and chaired by the CSE & Missing Coordinator in the first instance or if they are not available, a Child Protection Adviser. A plan of investigation and intervention should be drawn up at this meeting and implemented by the allocated social worker and/or team. Decisions to progress to CP conference should be taken in the usual way. Medium risk cases should be referred to MASE Panel. MASE referral form should be completed in liaison with the CSE & Missing Coordinator.

High Risk
A strategy meeting should be held and chaired by the CSE & Missing Coordinator in the first instance or if not available a Child Protection Adviser. A plan of intervention should be drawn up at this meeting and implemented by the allocated social worker and / or team. The decision about whether to progress to a CP conference needs to be taken on a case by case basis and be contingent on the level of risk and the level of support of parents etc. High risk cases should be referred to MASE Panel. MASE referral form should be completed in liaison with the CSE & Missing Coordinator.
Information sharing and consent for referrals

Responsibility for decisions about sharing information such as when to share information, how much information to share and how to share it - rests with your organisation so you should follow your organisation’s information sharing policy in addition to data protection legislation.

To make a referral to Children’s Services initially, you will only be asked for the basic identifying details of the child and family in question as well as the reason for the referral. This very basic level of information is unlikely to conflict with your organisation’s information sharing policy.

Obtaining consent to make a referral
Where there is no immediate safeguarding concern about a child, but additional services and help are needed to support a child in need – consent of the child/family must be sought.

However, if the child has been harmed or is at risk of harm or abuse – it is not necessary to gain consent to refer the case to Children’s Services.

Other instances in which you may consider making a referral without the parent’s consent:

✅ If seeking consent puts the child at increased risk.
✅ If seeking consent would cause delay which significantly adds to the risk.
✅ If the concern is about sexual abuse, forced marriage, ‘honour’ based violence, female genital mutilation, fabricated or induced illness in a child.

✅ If the child or young person has the capacity to understand and make their own decisions to give (or refuse) consent to sharing information about themselves. It is presumed that young people over the age of 16 have sufficient understanding. Children aged 12 and over may generally be expected to have sufficient understanding.

You should use professional judgement and your knowledge of the child to determine whether they have sufficient understanding of what they are consenting to and the ability to weigh up the implications.

Other key points to note:
• In the majority of cases you should obtain the parent’s consent; if you attempt to make a referral without obtaining consent - you will usually be asked to go back and obtain one
• It is important to distinguish between telling a parent you are making a referral and seeking their consent. Consent means the parent understands the purpose of the referral and is in agreement to their information being shared for the purposes of accessing the services involved in delivering the help needed. Consent is usually obtained in writing such as on the Early Help Assessment and Plan form or similar
• The overwhelming majority of parents will give consent and appreciate practitioners who are honest and direct with them and inform them what action they intend to take.
If you are unable to obtain consent or think it may not be appropriate to seek it and you would like some advice, talk to:

• The designated or named safeguarding lead professional or relevant manager in your organisation, as the decision to share personal information about a child or family rests with your organisation.
• ECIRS on 020 8825 8000
• Ealing’s Child Protection Advisers (CPAs) on 020 8825 8930

To find out more about information sharing visit www.gov.uk and search ‘Information Sharing for Practitioners and Managers’.

Seven golden rules of information sharing (taken from Section 2 of the DfE publication Information Sharing for Practitioners and Managers)

1. The Data Protection Act is not a barrier to sharing information, but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
4. Share with consent where appropriate and where possible – respect the wishes of those who do not consent to share confidential information. You may still share information without consent, if in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. Base your information sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
6. Ensure the information is necessary, proportionate, relevant, accurate, timely and secure. The information you share should be necessary for the purpose for which you are sharing it, only shared with those who need to have it, is accurate and up-to-date, is shared in a timely way and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.
Allegations against staff or volunteers

All services and organisations have an obligation to employ safer recruitment procedures (either following advice given in Ealing’s Child Protection Procedures or by developing their own safer recruitment policy).

And services and organisations also have an obligation to ensure appropriate safeguarding training is delivered to all staff and volunteers working with children including, guidance on appropriate behaviour around children and extended to data protection, the taking and storing of digital images, use of mobile phones and phone cameras etc when working with children.

If an allegation is made against a member of staff or a volunteer - it is a requirement of the Working Together to Safeguard Children Guidance that the Designated Officer is informed within one working day and prior to any further investigation taking place.

This procedure must be followed if any person has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child
- Behaved towards a child or towards children in a way that indicates he or she may not be suitable to work with children.

It is important to note that having a sexual relationship with a child if in a position of trust in respect of that child, is an offence even if consensual (sec16-19, Sexual Offences Act 2003).

Contacting the Designated Officer and Child Protection Team

The Designated Officer for the London Borough of Ealing can be contacted on 020 8825 8155 or 020 8825 8930.

If for whatever reason, you are unable to contact a member of the Child Protection Team, please call ECIRS on 020 8825 8000.
Making a complaint

Ealing Children’s Services is committed to providing a safe, timely and high quality service. There may be genuine differences of opinion about how to respond to a referral or how to help a child or family.

However, if you are dissatisfied with the level of service for any reason - there are a number of routes professionals can take to raise complaints or seek to resolve disagreements.

The Ealing Safeguarding Children Board has adopted the London Child Protection Procedures guidelines on conflict resolution. In essence there are four steps:

1. Professionals should attempt to resolve differences through discussion and/or meeting within a working week or a timescale that protects the child from harm (whichever is less).
2. Most day-to-day inter-agency differences of opinion will require a LA children’s social care team manager to liaise with their (first line-manager) equivalent in the relevant agencies, e.g. police detective sergeant, named or designated health professional or designated teacher.
3. If agreement cannot be reached following discussions between the above first line-managers within a further working week or a timescale that protects the child from harm (whichever is less), the issue must be referred without delay through the line management to the equivalent of operational manager/detective inspector/head teacher or other designated senior professional.
   Alternatively (e.g. in health services), input may be sought directly from the designated doctor or nurse in preference to the use of line management.
4. If professional differences remain unresolved, the matter must be referred to the heads of service for each agency involved.

It is important that if any professional thinks the actions taken or proposed will not adequately safeguard or help a child or family that they raise these concerns immediately.

If a child or family wishes to complain they can do so under the Children Act 1989 and the Representation Procedure (Children) Regulations 2006.

Complaints can be made to:

Customer Care Team (Children’s Services)
2nd Floor, Perceval House
14-16 Uxbridge Road
London W5 2HL
020 8825 8100
complaints_childrens_services@ealing.gov.uk
To download additional copies of this guide visit [www.ealing.gov.uk](http://www.ealing.gov.uk) or for print copies email [children@ealing.gov.uk](mailto:children@ealing.gov.uk)

Any feedback, comments or suggestions for future editions should be made to [children@ealing.gov.uk](mailto:children@ealing.gov.uk) in the first instance.