Working Together 2010 - Summary of key changes

NB whilst this document aims to alert readers to significant changes introduced in Working Together 2010, it may not include mention of ALL changes.

PART 1: Statutory Guidance

Chapter 1: Introduction
Key changes include:
- New section on the importance of the child in focus.
- Definition of children at risk widened.
- New importance of child’s perceptions inserted.

Specific changes:
- The child in focus (p32, 1.15-18) summarises the duties under Children Act 2004 relating to ascertaining the wishes and feelings of children and young people before making decisions to protect them. Further definition of keeping child’s voice heard includes involving the child in decision making, eliciting their wishes for the future and inviting them to make recommendations.
- Children at risk definition (p33, 1.22) now includes young people at risk of harm from community based violence such as gang, group and knife crime.
- New expectation on communicating effectively with children includes a reference to use of interpreters (p37, 1.31).

Chapter 2: Roles and Responsibilities
Key changes include:
- New emphasis on effective collaboration across all agencies and duties of Directors of Children’s Services.
- New sections on Early Years, UK Borders Agency, CRB checks.
- New section on Care Quality Commission.
- New roles for PCT/commissioning.
- New general principles for Health Providers.
- New reference to MARACs.
- UKBA responsibilities on trafficking.

Specific changes:
- New statutory duties including the specific duties of DCSs under section 18 of the 2004 Children Act (p40, 2.3)
- New statutory guidance on safer recruitment, Safeguarding Children and Safer recruitment in Education, due to be updated in 2010, is referenced and prescribed as a standard for academies and independent schools (p41, 2.5)
- New duties for Early Years providers under section 40 of the Childcare Act 2006 (p41, 2.6)
- UK Borders Agency duties from section 55 of Borders, Citizenship and Immigration Act 2009 to promote well being and safeguard children (p41, 2.8)
• Expectations on all organisations regarding CRB checks (p42, 2.9)
• A significant expansion on infrastructure for all organisations providing services to children, parents or families, taking into account the importance of explicitly stating safeguarding policy within commissioning strategies; a culture of listening to children; a complaints procedure and the importance of understanding online risks (p42, 2.11)
• A new section on CAF emphasising its importance, its use in supporting referral or specialist assessments but that CAF is not a referral form and the absence of a CAF should not be a barrier to accessing resources (p44, 2.16-7)
• New emphasis on the benefits of an integrated and co-located workforce. Also the critical role of the Children’s Trust Board in ensuring proper commissioning of services (p45, 2.18/9)
• Special consideration must be given to support for CYP (p47, 2.24) and information sharing processes
• An awareness of the importance of working with adult social care is made clear (p48, 2.28) and for working with Tenant Services Authorities (p49, 2.31)
• The Safe Networks role in supporting sport, culture and leisure services (p50, 2.33)
• For Health colleagues, a new reference to CQC and registration requirements (p52, 2.42); a new emphasis on Strategic Health Authorities and their membership of the LSCBs (p53, 2.48)
• For PCTs, a new responsibility for PCT Chief Executives to ensure the health contribution to children’s safeguarding is discharged as well as a named public health professional, new specifications for PCT commissioners and responsibilities for GPs (p54, 2.53-2.58)
• PCTs are expected to bring together commissioning services expertise on Sexual Assault Referral Services (p55, 2.59)
• For Serious Case Reviews, PCTs must notify the SHA and CQC of all SCRs and ensure that links are made between health providers (p55, 2.60)
• A new section on general principles for health service providers, including contributing to child death reviews and SCRs (p57, 2.64)
• An expectation that all health professionals will commonly complete CAFs (p57, 2.65)
• The Healthy Child Programme and the importance of regular health reviews are stressed (p61, 2.79-2.80) together with expectations on dealing with referrals appropriately and with being aware of adults illness or behaviour posing a risk to children (p62, 2.83-4)
• Greater emphasis on the contribution made by Health Visitors (p62, 2.88-2.92)
• Greater emphasis on the role of School Nurses in early intervention and CAF (p63, 2.93-5)
• Police duties updated to reference ACPO publication Investigating Child Abuse and Safeguarding Children 2009 (p70, 2.124) and the role of National Police Training Agency for specialist CAlTs
• Updated to reflect the role of MARACs and MAPPA processes (p71, 2.126)
• The Probation service’s duties are updated (p73, 2.133)
• Greater clarity on the responsibilities of YOIs, STCs, SCHs and the YJB to safeguard children and young people from themselves, adults and peers and to share information with the LSCB and ensure that staff are trained and safer workforce practices in place (p74-75)
• UKBAs duties to promote the safeguarding of children (p76, 2.150) including identification of and response to trafficking (p77, 2.153)
• Schools and FEs: includes reference to new Ofsted inspection framework (p78, 2.155) support and planning for young people in custody and requirements for 14-16 year olds, including children educated off site in ‘extended vocational placements’ (p78, 2.156)
• Greater emphasis on the contribution made by Early Years settings to safeguarding (p80, 2.166-2.171)

• Faith communities duty to report people who pose a risk to children direct to LADO (p86, 2.192) and faith groups duty to have effective arrangements for working with sexual and violent offenders (p86, 2.193).

Chapter 3: Local Safeguarding Children Boards

Key changes include:

• The requirement for LSCBs to produce and publish an annual report on the effectiveness of safeguarding in the local area.

• The appointment of two representatives of the local community to each LSCB.

• Statutory representation on the LSCB of schools.

• Provision to ensure appropriate information is disclosed to the LSCB in order to assist it in the exercise of its functions (subject to the passage of the Children Schools and Families Bill).

• Further clarity over roles of the LSCB and the Children’s Trust Board, including the requirement for the Chair to be someone independent of the local agencies.

Specific changes:

• The **scope** in relation to **universal** safeguarding has two additions, reflecting the priorities of PSA13;
  - work to prevent accidents and other injures and, where possible, deaths
  - work to prevent and respond effectively to bullying (p88, 3.8).

• Children who might require **targeted** or proactive work now includes;
  - children missing from school or childcare
  - children in the youth justice system (in addition to those in custody)
  - children and young people affected by gangs (p89, 3.9).

• Children who might require **protection** now includes;
  - children abused through sexual exploitation (change from ‘prostitution’)
  - children affected by parental mental ill health
  - young victims of crime (p88, 3.10).

• LSCB functions as distinct from those of the Children’s Trust Board, including some new requirements:
  - the LSCB should work with the Children’s Trust Board to develop thresholds and processes (p91, 3.16)
  - the Children’s Trust Board working with the LSCB should ensure that local arrangements for use of the CAF are clearly distinguished from the need to refer a child to children’s social care services (p91, 3.17)
  - LSCBs required to quality assure agencies recruitment practice, including carrying out audits to ensure compliance with vetting requirements (p91, 3.21)
  - strengthening the requirement of LSCBs to lead and challenge practice across agencies including commissioned services in respect of private fostering. In particular to respond to;
    - the annual report submitted by the LA to the LSCB
    - Any Ofsted inspection of Private Fostering arrangements
  - LSCB annual report to refer to private fostering ‘as appropriate’ (p92, 3.23)

• Considering the need for additional policies or procedures to be developed, includes a new category ‘procedure for handling complaints regarding requests to share information’ (p93, 3.26)

• Requirement to ensure links to secure settings (p94, 3.31-3.33) with arrangements for;
  - scrutinising restraint techniques
  - monitoring use of restraint
  - being notified of any incidents/injuries arising from use of restraint
  - submitting an annual report to the YJB (more frequent if required)
• New statutory Annual Report function including specific topics for inclusion and deadline for first submission of 01.04.2011 (p94, 3.34-3.39)
• New requirement on CTBs to respond to annual report through CYPP (p95, 3.38)
• New paragraph clarifying the governance and accountability arrangements (p97, 3.49)
• Updated SCR functions in line with revised Chapter 8 (p97, 3.44)
• New diagram mapping out the way in which the LSCB contributes to improved outcomes (p98)
• Distinction made between the complementary roles of the CTB and LSCB and the requirement to have two Chairs (p99, 3.52-3.59)
• Further clarity is provided about the responsibility and accountabilities of Chief Executives, Council leaders, lead members for Children’s Services and the DCS to ensure that safeguarding arrangements and the relationship between the Children’s Trust Board and the LSCB is working effectively (p101, 3.61 and p102, 3.64-3.68)
• Clarity about membership–additions/clarification re roles and governance
• Representation from those providing adult drug and alcohol services (p103, 3.71)
• provision for 2 lay members–reasonable steps to be taken by LSCBs, to identify, train and support lay members whose function will be to enhance links, engage communities and provide challenge (p104, 3.74-3.77)
• Requirement for a cross section of representation from schools (p104, 3.78)
• Changes to other members, updated to include FIP and MARAC reps (p106, 3.83)
• Reference to further advice on SHAs engagement with LSCBs (p107, 3.85)
• New section on information sharing for the purposes of carrying out LSCB functions (p108, 3.94)
• Section on planning updated to include CYPP requirement and consideration of integrated frontline delivery and aligning or pooling budgets, and the requirement that the voice and experiences of children and young people should strongly inform the LSCBs work programme (p110, 3.104-3.107)
• Introduces a new function for the LSCB to monitor safeguarding performance by all partners through a peer review process, self evaluation process, data and self audits (p111, 3.108)
• Where a CTB partner’s is not performing effectively in safeguarding, the LSCB should involve, where appropriate, relevant monitoring bodies such as, Government offices/SHAs, relevant inspectorates or if necessary the relevant government department (p111, 3.109)
• Updated to reflect new inspection arrangements and the LSCBs role and contribution to those (p111, 3.110 -3.112).

Chapter 4: Training and development for inter-agency work
Key changes include:
• Greater detail about the specific requirements for different groups of staff within the Children’s Workforce, and
• The responsibilities for training delivery between the Children’s Trust and the LSCB.

Specific changes:
• Evidence from research which shows that interagency training is highly effective in helping professionals understand their roles, responsibilities; procedures; assessments and decision making (p112, 4.3).
• There is a responsibility on employers (not individual agencies) to ensure their staff are competent and confident in carrying out their safeguarding responsibilities in accordance with WT (p114-115)
• This will include a mandatory induction which will incorporate familiarisation with their child protection responsibilities, policies and procedures. Induction should be completed
within the first six months of employment and before individuals take part in interagency training. Refresher training should take place every three years (p113, 4.7)

- Through their work on the CYPP, Children’s Trust Boards are responsible for ensuring that workforce training strategies and delivery are in place, the LSCB should contribute to this. The LSCB or Children’s Trust may manage the delivery of training, but if the LSCB provides the service there must be an agreed protocol in place between the CT and the LSCB to ensure the LSCB will be called to account, ensuring that it acts in accordance with the CYPP (p116, 4.17 – 4.18)
- Research indicates where LSCB’s manage inter-agency training this is highly effective. (p116, 4.17)
- LSCBs should ensure that all staff who work or have contact with children are appropriately trained to understand normal child development and to recognise potential signs of abuse and neglect (p116, 4.19)
- LSCBs should review and evaluate effectiveness of single and inter –agency training and report annually to the Children’s Trust (p116, 4.20)
- Where LSCBs have the responsibility for delivery they should ensure adequate funding arrangements (p116, 4.21)
- Research suggests over-reliance on single-agency training co-ordinator makes LSCB training programmes vulnerable (p116, 4.22)
- Induction and training for LSCB members, including lay members, independent chairs and any employees of the LSCB should be provided to support them to fulfil their responsibilities effectively (p117, 4.23)
- Revised levels of training for different professional roles including operational managers, senior managers and members of LSCBs. This includes suggested training content, training methods and defines employer, LSCB and CT responsibilities (p118, 4.30 and Table 1 p125)
- More detailed expectations of LSCBs in the planning, organisation, delivery, quality assurance and evaluation of training (p121, 4.43 – 4.47)
- Revised section on the need for effective support and supervision for all staff with reference to the Social Work Task Force’s recommendations to establish a national standard for supervision for Social Workers (p123, 4.48-4.55)
- New table on suggested training for different target groups (p125–131)
- The content of all training programmes are to be reviewed and updated in the light of changing policy, legislation, research, SCR’s, Child Deaths.

Chapter 5: Managing Individual Cases

Key changes include:

- Increased focus on the child- ensuring that direct contact takes place/observation of the child/child seen alone where appropriate and that a therapeutic relationship is developed with the child, with good analysis undertaken and an emphasis on good recording
- Clarification of the relationship between the CAF and the IA
- Extension of timescales for completion of the IA from 7 to 10 days
- Strengthening the assessment of significant harm, and the engagement of all partners
- Integration of the planning and review process for children subject to CP plans who are also looked after.

Specific changes;

- Children living in custodial settings should be assessed as potential children in need (p137, 5.9)
- Children subject to Court Ordered Secure Remand should automatically acquire the status of looked after child (p137, 5.9)
- Reminder of the impact of domestic violence, parental substance misuse, mental illness and/or learning disability (ref Chapter 9)
• New section clarifying links to the CAF process (p138, 5.12); undertaking a CAF is not a pre-requisite for a referral being accepted by the local authority (p139, 5.17) but it may inform the IA (p146, 5.39); undertaking a CAF may be a suggested ‘next step’ following a referral to social care which does not result in an IA (p144, 5.34)
• Any decisions not to share information regarding sexual activity involving under 13s should be exceptional and made with the documented approval of a senior manager (p141, 5.27)
• New clarification that the referrer should have the opportunity to discuss their concerns with a qualified social worker (p143, 5.32)
• Clearer expectations of first line social work managers decision making responsibilities (p144, 5.34; p147, 5.41)
• Initial assessment timescale changes to 10 working days (p145, 5.39)
• Clarification that the initial assessment should be led by a qualified and experienced social worker who is supervised by a highly experienced and qualified social work manager (p147, 5.41)
• Clarification over use of term ‘significant harm’ in preference to ‘risk’ (p150, 5.49)
• Clearer expectations about establishing the child’s wishing and feelings and the social worker seeing the child as part of the S47 enquiries and that the date this was undertaken and whether this was alone is clearly recorded in the outcomes of the enquiry and in the LA report for conference, as well as seeing the child alone at least six weekly as part of a protection plan (p153, 5.58; p155, 5.64; p158, 5.74; p165, 5.91; p172, 5.115)
• Changes to the section on ‘purpose of the ICPC’ to include the need to take into account family history and present and past family functioning to determine whether the harm is continuing and ‘significant’ (p161, 5.82)
• Clarification of the timing of the ICPC; all ICPCs to take place within 15 days of the strategy discussion or the strategy discussion at which the S47 investigation was initiated if more than one strategy discussion is held (p162, 5.83)
• Attendance at ICPCs being sought from a wider range of professionals who work with the parents particularly in relation to substance misuse, domestic violence and learning disability (p163, 5.84)
• If invited professionals unable to attend a CP conference they should seek to send a well briefed agency representative in their place (p163, 5.85, p179, 5.140)
• Greater detail about the content of reports for ICPCs referring to the information gathered using the Assessment Framework and placing greater emphasis on analysis and recommendation (p165-166, 5.91-5.92)
• LA report to ICPC to contain recommendations to the conference (p116, 5.92)
• The outline plan developed at the conference, the decision of the conference, the name of the lead social worker and the core group membership should be recorded appropriately and circulated to all those invited to the conference within one working day (p168, 5.102)
• Clarity about the relationship between the CP conference plan/review and a decision made by the LA for the child to become looked after, and the consequent CLA plan/review (p168, 5.103 and p180, 5.144 - 5.148)
• Agencies to take responsibility for ensuring that their staff participate in core groups effectively (p172, 5.116)
• The ‘lead social worker’ as a term, replaces the use of lead professional in a number of places. The lead social worker is responsible for visiting, ensuring that the child is seen alone where appropriate and developing a therapeutic relationship with the child and chairing the core group and ensuring there is a record of core group meeting decisions (p172, 5.113; 5.115; p173 5.119; p175, 5.123-5.124)
• Clarification that core assessment is completed when shared with child/family and when team manager has authorised it (p173, 5.120)
• Greater emphasis on the importance of good analysis (p174, 5.121)
• A requirement that the CP plan specifies the frequency and purpose of contact between specific named professionals and the child and whether seen alone or with other family members or care givers present (p174, 5.123)
• Responsibility of the LA to consider what legal action it should take if parents are not willing to cooperate with protection plan (p175, 5.124)
• Change of approach from ‘agreeing’ to ‘negotiating’ the plan with parents (p176, 5.127)
• Greater focus on intervening effectively with families, requiring family history and previous interventions to be taken into account and suggesting a set of questions to be considered (p176, 5.128-129)
• Greater focus on review conferences considering explicitly whether the child continues to suffer or be likely to suffer significant harm and reiterating the LA responsibility to consider legal action (p178, 5.137-1.39)
• Clarification that in most cases where a child who is the subject of a PP becomes looked after it will no longer be necessary to maintain the PP but recognition of the need in a relatively few cases for children to be subject to both CP and LAC plans, and enabling arrangements to be made for reviewing the two plans simultaneously, recognising the different requirements for ‘independence’ and the representations required by agencies. Key principle is to ensure that the child/young person is central to arrangements (p180, 5.144-8)
• New requirement on GPs to ensure that information from a child’s initial and review CP conferences is retained and incorporated into the child’s health record (p184, 5.160).

Chapter 6: Supplementary guidance on safeguarding and promoting the welfare of children
Key changes include:
• Additional and supplementary guidance on complex or specialist cases.

Specific changes:
• A new updated section on sexually exploited children making reference to the guidance, “Safeguarding Children and Young People from Sexual Exploitation”, June 2009, noting strong links between sexual exploitation, running away from home, gang activity, child trafficking and substance misuse (p191, 6.2)
• A new section on children affected by gang activity referring to recently published guidance, “Safeguarding Children and young People who may be affected by Gang Activity”, DCSF 2010 (p192, 6.5)
• An update on fabricated or induced illness to include reference to, “Safeguarding Children in Whom Illness is Fabricated or Induced”, DCSF 2008, and reference to training material for practitioners and managers “Incredibly Caring “, 2009, in the form of DVD (p192, 6.6)
• Investigating complex (organised or multiple) abuse, no major changes except ACPO have also recently issued revised guidance, “Investigating Child Abuse and Safeguarding Children”, produced by CEOP www.homeoffice.gov.uk (p194, 6:13)
• An updated section on forced marriage and honour based violence to reflect changes in, “Multi-agency practice guidelines. Handling cases of Forced Marriage”, Ministry of Justice 2009 (p197, 6.20)
• A new section on the abuse of disabled children reflecting, “Safeguarding Disabled Children- Practice Guidance”, DCSF 2009. Provides a framework for LSCB agencies and professionals at a local level, individually and jointly, to devise and agree detailed ways of working together to safeguard disabled children. Reference to growing evidence that disabled children, especially those with complex needs, are at increased risk of abuse (p202, 6.43)
• In criminal proceedings, disabled witnesses aged under 17 (to be raised to 18 by the end of 2010) may be eligible for giving evidence in court, i.e. through video link (p203, 6.48).
• A new section on child abuse linked to belief in spirit possession, reflecting guidance, “Safeguarding Children from Abuse Linked to a Belief in Spirit Possession”, DCSF 2007 (p204, 6.49)

• A new section on child victims of trafficking, setting out risks of sexual exploitation and multi-agency responses based on guidance, “Safeguarding Children who may have been trafficked”, 2007, DCSF and Home Office (p205, 6.54).

Chapter 7: Child Death Review Processes

Key changes include:

• Involvement of parents/family members
• Revised definition of unexpected deaths
• Revised definition of preventable deaths
• A revised structure to provide a more logical and chronological approach to responding to both expected and unexpected child deaths
• Expanded guidance on the process in the light of experience in the field
• Clarity on the roles of registrars and coroners and increased clarity about how to respond appropriately to the deaths of children with life limiting illnesses.

Specific changes:

• Clarification that all child deaths up to the age of 18 years (excluding both those babies who have been stillborn and planned terminations of pregnancy carried out within the law) must be reviewed (p208, 7.1)

• Clarity that the unexpected death of a child with a life-limiting illness should be managed the same as any other unexpected death so as to establish the cause of death and any contributory factors (p209, 7.6)

• The specific section on involvement with parents and family members for all child deaths describes best practice as to how to inform and involve parents and family members in the rapid response and child death overview processes (p209, 7.7 – 7.12)

• New guide for parents and carers – a leaflet which helps to explain the child death review process and where parents and carers can obtain further information, can be found on the Every Child Matters Website (p210, 7.7 footnote)

• In line with the Children and Young Persons Act 2008, Registrars are required to supply LSCBs with information about the deaths (p211, 7.15)

• Registrars are required to send information to the appropriate LSCB no later than seven days from the date of registration (p211, 7.16)

• LSCBs must make arrangements for the receipt of notifications and the publication of these arrangements, by notifying DCSF of the name and email address for the child death overview designated person to whom notifications are sent. This information will be published on the ECM website (p211, 7.17)

• Duty on coroners to inform the LSCB of any inquest or post mortem for a child who has died, as well as more guidance around information sharing between coroners and LSCBs (p212, 7.18- 7.19)

• The new definition of ‘unexpected death’ also advises professionals to consult the designated paediatrician when clarity is required. If in doubt then the processes for unexpected child deaths should be followed until available evidence enables a different decision to be made (p212, 7.21-7.22)

• The new definition for preventable child death incorporates the term “modifiable factors” which may have contributed to the death (p213, 7.23)

• Guidance around the process and governance for CDOP including membership and roles and responsibilities (p213, 7.25 – 7.31)

• Greater clarity over residency and responsibility for reviewing the death of a child (p215, 7.34)
• Guidance on use of forms and on receiving agency reports (Form B), including a timescale of three weeks from the date of notification (p218, 7.38-7.39)
• Scope for the CDOP to review groups of similar deaths (p219, 7.44)
• Guidance around other related processes highlights how CDOP should align itself with other processes and/or organisations (p221, 7.51-7.56)
• Comprehensive revised guidance on rapid response when responding to the unexpected death of a child at all stages of the process (p223, 7.57-7.94)
• Greater emphasis on the role of the CDOP in contributing to the LSCBs work in preventing child deaths, including guidance on the content of the annual report to the LSCB (p231, 7.95).

Chapter 8: Serious Case Reviews
Further amendments made to chapter issued in December 2009:
• Cross reference to child death procedures (chapter 7) and SCR process (p235, 8.10)
• Further advice on the format and content of the Serious Case Review Executive Summary (p250).

PART 2 Non-Statutory Practice Guidance

Chapter 9: lessons from research and inspection
• Sections on the impact of domestic violence, parental mental ill health, parental problem drug use and parental problem alcohol use have been significantly developed.
• A section on parental learning disability has been added in light of the learning about the impact of these issues on children and young people and the increased understanding of agencies responsibilities to support parents and safeguard children from the risks that can arise.

Chapter 10: Implementing the principles on working with children and their families
• New section on children in families at risk having very poor outcomes and the need to intervene early where there are risk factors (p287)
• A new section on Think Family practice, effectiveness of parenting and family interventions, working with fathers and family intervention projects (p289-291)
• New section on Family nurse partnerships and their effectiveness in intervening with vulnerable young people and their babies, across the range of need from CAF and LP to identifying those in need of protection.

Chapter 11: Safeguarding and promoting the welfare of children and young people who may be particularly vulnerable
Key changes include:
• New focus on all those who work with children to be aware of their development and that LSCB procedures apply in every situation and in all settings
• A wider description of responsibilities for children in prison
• Links to Anti Social Behaviour teams and adult services are key
• A new section on Violent Extremism
• A revised section on Domestic Violence
• Revised guidance on runaways
• Revised section on UASCs.

Specific changes:
• Increased emphasis on LSCB procedures applying in every situation and in all settings, and specific reference to children living away from home and out of area (p292,11.2-4)
LAs are reminded of their duty to notify host authorities when Looked after children are placed in another LA area, to maintain and update assessments and care plans, to ensure care plans are regularly reviewed and to generally comply with the relevant National Minimum Standards (p294-5)

A new section on children in contact with the youth justice system clarifying the role of the YOTs (p299)

Increased emphasis on improved planning for children in custody, managing the risk of re-offending and YOTs providing a named caseworker (p300, 11.33-4)

Procedures to be established between secure provisions and the LSCB (p300, 11.38) and continuity of services in and out of the secure estate including continued access to health services (p300, 11.39 and 11.42)

LA responsibilities for LAC children in prison are clarified, with the LA retaining its corporate parent responsibility for some children whilst those previously accommodated under a voluntary agreement should have a representative appointed to assess their needs and to prepare a pathway plan for support for children 16+ looked after before being sentenced (p301, 11.43)

A revised section on abuse by children and young people setting out the requirements to meet the child’s needs as well as manage the risks they present, with greater emphasis on the multi agency approach (p302, 11.53-4)

Bullying- overarching guidance on dealing with bullying including homophobic bullying, together with off site bullying guidance published April 2009 (p306, 11.60-1)

Lack of parental control: – arrangements to be in place with local safeguarding adults teams where children are involved in abuse or in households with vulnerable adults (p307, 11.69)

Reminding schools of the range of strategies available for engaging with parents, including parenting orders and Parent Support Advisers (p308, 11.70-2)

Violent Extremism-new section defines violent extremism and the children who are particularly vulnerable. All partnerships must have agreed processes in place for safeguarding vulnerable individuals, including use of the CAF which can operate alongside other strategies such as Channel (p309, 11.74-8)

Domestic Violence - all professionals should ask direct questions on DV, and be alert to links with other factors such as drug and alcohol misuse. All children and women should be given the chance to be seen alone (p311, 11.82-3)

Removing an abusive partner should be considered first (p312, 11.85)

Relations should be in place so the police are aware of children subject to a CP plan and referrals to MARACS should be made (p312, 11.86)

Additional practice guidance including that referrals to social care should be made if there is a single DV incident, if the child is under 12 months (p312, 11.88) and that contact from an abusive partner must be risk managed (p313, 11.89)

Runaways –protocols with children’s services and police and others should be in place, including an inter-agency framework, a CAF where necessary. Return interviews should be carried out (p317, 11.101-2)

UASCs – LAs to adopt the same processes as they would with other children, but careful thought needs to be given on the services provided (p320, 11.113-4)

Close links need to be built with the UKBA case owner and the social worker needs to plan and seek up to date information on the progress of the case (p320, 11.115-6).

Chapter 12: Managing individuals who pose a risk of harm to children

Specific changes:
- New emphasis on young people who may pose a risk of harm to children, and the role of YOTs (p 324, 12.13).
- Updating in accordance with the MAPPA process includes requirements for the Strategic Management Boards to maintain working relationships with the LSCB (p325, 12.16)
• Broader definition of MAPPA ‘Eligible Offenders’, e.g. includes those disqualified from working with children (p325, 12.17)
• Duty on YOTs to identify cases that meet the MAPPA criteria and make appropriate referrals. Although young people should be assessed and managed differently from adults using age appropriate assessment tools. Children’s Social Care should always be represented at MAPPA meetings where a young person is being discussed (p327, 12:24)
• New section on MARAC’s (p328,12:26- 31)
• A new section on the Vetting and Barring Scheme and the role of ISA replacing the section on POCA and list 99 (p329, 12:32 – 39)
• The section on CRB checks makes refers to intention to consult on proposals to amend requirements for CRB disclosures once individuals have been ISA registered (p331, 12:39)
• New requirement on young people who have offended and received a conviction or caution for certain sexual offences to notify the police of their whereabouts in the community (p331, 12:40)
• New section describing the Child Sex Offender Review Disclosure Process and the intention to roll out nationally from August (p332, 12:46 – 12:54)
• New section describing Violent Offender Orders, civil orders which may be used to manage offenders who pose a serious risk of harm to children (p335, 12.68).

Appendix One - Statutory Framework
• Incorporates reference to Statutory basis for ContactPoint (CA 2004 Section 12) and new S12A of CA 2004 (Children’s Trusts)
• Table A amended to reflect new partners and new duties.

Appendix Two - Framework for the Assessment of Children in Need; exclusion of last two components of ‘family and environmental factors’, ‘family’s social integration’ and community resources’.

Appendix Three - Use of questionnaires and scales; no change.

Appendix Four - MoD Child protection contacts; updated.

Appendix Five - Procedures for managing allegations against people who work with children;
• Updated to incorporate the employer’s duty to refer to ISA rather than POCA or List 99 (p357, 3; p359, 9; p362, 28)
• Lessons learnt now include specific consideration being given to decisions to suspend members of staff (p363, 30).

Appendix Six - Faith Community contacts and resources; new section.

Appendix Seven - Guide to acronyms; updated.

References and internet links; chapter by chapter reference guide plus links to internet sites where they exist.

Safeguarding Team, GOSE
and the London Regional Safeguarding Advisers.
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