# Bath and North East Somerset (B&NES) Community Safety and Safeguarding Partnership Threshold Document

# Assessing Risk, Impact and Needs of Children and Young People in B&NES

# Introduction

This document is part of a suite of documents created to establish the B&NES Community Safety and Safeguarding Partnership. The new Partnership replaces the existing Local Safeguarding Children Board, the Local Safeguarding Adult Board and the Responsible Authorities Group from 29th September 2019. The Partnership will meet the statutory requirements for all three arrangements. The change in legislation has provided an exciting opportunity to create a new Partnership with a commitment and focus on Think Family and Community.

This Threshold Document focuses on the needs of children and young people and meets the statutory requirements of the new local safeguarding arrangements for children and young people in B&NES.

The Threshold Document was approved by the existing B&NES LSCB meeting in June 2019.

# The Five Levels of Need

Our vision in Bath and North East Somerset is that children have the best possible start in life and have access to well-coordinated, good quality and timely Early Help when it is required, so needs can be identified and addressed to promote fulfilling family lives.

Most children, young people and families in Bath and North East Somerset enjoy a good quality of life; however, there are some who find life more difficult for a variety of reasons. This document illustrates the different levels of need experienced by children, young people and families and outlines an approach for assessing these within the context of their families and communities. The five levels of need portrayed here reflect how children and young people often move in a non-structured way between and across levels and how any assessment should reflect the views and aspirations of children, young people and their families and their wishes in partnership with a wide range of professionals and agencies.

This document also illustrates the associated risks and potential impact which should be the determining factor in identifying and agreeing needs and interventions with the child, young person and their family. This model is based on the fact that all children, young people and their families, whatever their needs, will be supported at a Universal Level throughout. Universal services include GPs, Health Visitors, Midwifery and Educational Establishments. Information about wider universal services for families is available at https://www.bathnes1bd.org.uk/

**Early Help**: the concept of Early Help is simple; by working together with children, young people and families problems can often be prevented from occurring, or when they do families may be offered better support in order to stop them getting worse. Where needs cannot be met at a Universal Level and additional needs are identified, children, young people and families may require extra support from universal and/or early help services to prevent needs escalating. Needs should be identified through either a single agency assessment or multi-agency Early Help Assessment to inform the response required to effect positive change.

Early Help is provided by a broad range of agencies including the voluntary and charitable sector as well as the council and other public sector

organisations. An individual child, young person and family, often require a multi-agency response to meet their needs so it is essential that an Early Help Assessment is carried out to identify needs to determine how best agencies can work together as early as possible to improve outcomes for children, young people and their families.

Parents are responsible for meeting their children's needs and keeping them safe and they are in the strongest position to do this when their own needs are met. This is the case for the majority of children and young people in B&NES, but some grow up with a parent or carer who at some point experiences mental ill health, substance misuse or domestic abuse in the home, or for some other reason are not able to meet their child's needs. This can have a significant impact on the wellbeing and life chances of children in the family, particularly where there are other contributory factors such as parent having had poor childhood experiences, poverty, family debt and poor housing.

B&NES has adopted the principle of **Think Family** and **Think Community** across all adult and children's services and as such all agencies should consider children and young people within the context of their families and communities. For further information on B&NES Early Help Offer, Assessment and Strategy: https://www.bathnes.gov.uk/services/children-young-people-and-families/early-help-support-families

**Adverse Childhood Experiences**

Early identification of adverse factors that affect a child or young person through early help assessment is key to improving health, education and social care outcomes. Studies are increasingly identifying the importance of early life experiences on health and wellbeing outcomes throughout the life course. Individuals who have **adverse childhood experiences (**often referred to as ACE's**)** tend to have more physical and mental health problems as adults than do those who do not have ACE's and ultimately greater premature mortality. ACEs include harms that affect children directly (eg, abuse and neglect) and indirectly through their living environments (eg, parental conflict, substance abuse, or mental illness).

In addition evidence indicates how childhood exposure to chronic stress leads to changes in development of nervous, endocrine, and immune systems, resulting in impaired cognitive, social, and emotional functioning. Individuals who have ACEs can be more susceptible to disease development through both differences in physiological development and adoption and persistence of health-damaging behaviors'.

**Neglect and Abuse**
Children may be vulnerable to **neglect** and **abuse** or **exploitation** from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including: sexual, physical and emotional abuse, neglect, exploitation by criminal gangs and organised crime groups, trafficking, online abuse, sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

**Exploitation**
There is an increasing awareness of the risks to children being exploited for criminal reasons by gangs, in particular the risk of involvement in 'county lines', and the recognised relationship in some cases between risk of child sexual exploitation and gang association.

**County Lines** is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

County lines activity and the associated violence, drug dealing and exploitation have a devastating impact on young people, vulnerable adults and local communities.

**Prevent and Radicalisation**
The Prevent programme is part of the Government’s counter-terrorism strategy, CONTEST. Its aim is to prevent people from becoming terrorists, or supporting terrorism. It is designed to ensure that individuals who are identified as being at risk of being drawn into terrorism are given appropriate advice and support so that they may turn away from radicalisation. Vulnerable young people are a target for radicalisation and radicalisation should be a consideration when making holistic assessments of vulnerable young people.

Whilst it is parents and carers who have primary care for their children, local authorities, working with partner organisations and agencies, have specific duties to safeguard and promote the welfare of all children in their area. The Children Acts of 1989 and 2004 set out specific duties, which are clearly defined in Working Together to Safeguard Children, 2018. These duties are referred to as Sections within the Acts:

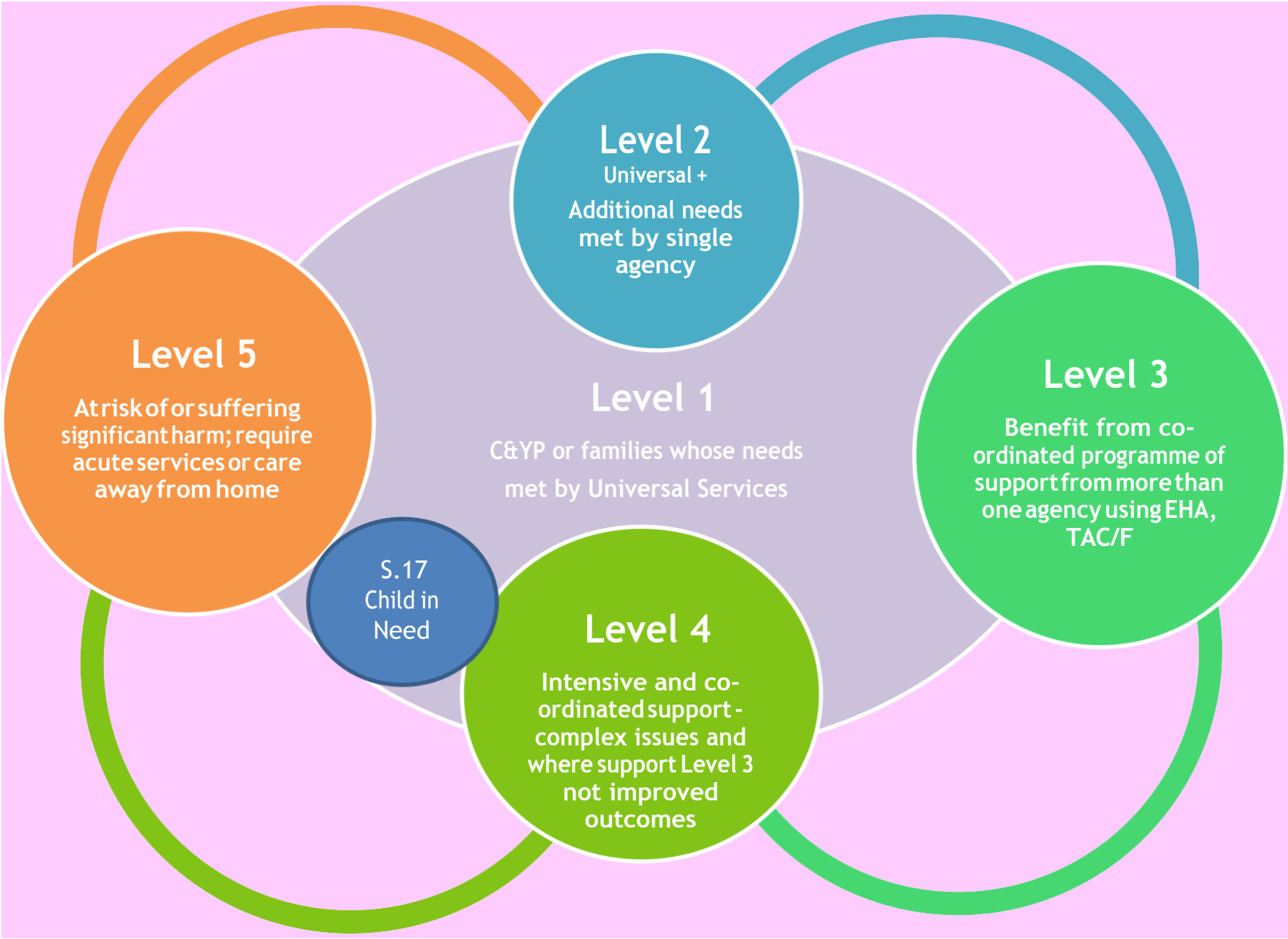
**Section 10** (Children Act 2004) the local authority is under a duty to make arrangements to promote co-operation between itself and organisations and agencies to improve the wellbeing of local children. This co-operation should exist and be effective at all levels of an organisation, from strategic level through to operational delivery.

**Section 17** (Children Act 1989) - children in need - puts a duty on the local authority to provide services to children in need in their area, regardless of where they are found.

**Section 20** (Children Act 1989) - duty to accommodate a child- some children in need may require accommodation because there is no one who has parental responsibility for them, because they are lost or abandoned, or because the person who has been caring for them is prevented from providing them with suitable accommodation or care, the local authority has a duty to accommodate such children in need in their area.

**Section 17 Young Carers** (Children Act 1989) -care and supervision orders- if a local authority considers that a young carer (see glossary) may have support needs, it must carry out an assessment under section 17ZA of the Children Act 1989. The local authority must also carry out such an assessment if a young carer, or the parent of a young carer, requests one. Such an assessment must consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer’s needs and wishes. The Young Carers’ (Needs Assessment) Regulations 2015 require local authorities to look at the needs of the whole family when carrying out a young carer’s needs assessment. Young carers’ assessments can be combined with assessments of adults in the household, with the agreement of the young carer and adults concerned.

**Section 47** (Children Act 1989) - reasonable cause to suspect a child is suffering or likely to suffer significant harm- requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm and to decide whether and what type of action is required to safeguard and promote the welfare of the child or young person.
The local authority should act decisively to protect the child from abuse and neglect including initiating care proceedings where existing interventions are insufficient. Where an assessment in these circumstances identifies concerns but care proceedings are not initiated, the assessment should provide a valuable platform for ongoing engagement with the child and their family.


Level 2
Universal +
Additional needs met by single agency
Level 5
At risk of or suffering significant harm; require acute services or care away from home
Level 1
C&YP or families whose needs met by Universal Services
Level 3
Benefit from co-ordinated programme of support from more than one agency using EHA, TAC/F
S.17 Child in Need
Level 4
Intensive and co-ordinated support - complex issues and where support Level 3 not improved outcomes

**How to Use this Document to support decision making**

This document aims to help you to identify the level of intervention most appropriate to support families as early as possible to prevent an escalation of their needs. The document has been designed to work alongside the B&NES Neglect Toolkit and you will find similar terminology used in both documents.

Based on the concept of risk and impact, when making an assessment of a child or young person, the first stage is to assess risk, the threshold is divided into five levels of need and it is important to look at the impact of the risk on the individual to be able to identify need. For some children and young people, the risks maybe similar but the impact will be greater for those with less resilience and instability in their lives. For some children and young people there may be a number of protective factors that mean although they are presented with similar risks the impact is not so great, this could include stable family life, non-offending parents, good friendship groups, positive regard for school, good attachment in their early years, good communication skills etc It is therefore important that as part of the analysis of risk, any protective factors are also taken into account. The Document outlines what support is recommended for each level of need, however professionals should always consider the impact within a holistic assessment of the individual and in partnership with the child, young person and family.
It is also important to remember that one of the values of undertaking an assessment is that it may help agencies supporting the child be clearer on what support is already there and how information has been shared so as to ensure the most appropriate action is taken. This may mean no additional resource but improved action plan to enable agencies to work together more effectively.

The next step is to consider the most appropriate agency to support the child, young person or family, referral to social care should only be when there is significant risk of harm or when all other possible interventions have been tried and have not been successful. You should consider what additional input social care can offer, this may be a statutory requirement.

Children and young people will move between different levels of need and their assessment should be updated as needed to ensure the appropriate level of support and intervention is offered to the child, young person and family. The aim of the intervention should have clear outcomes and there should be regular reviews to ensure if needs cannot be met the impact of the risk be reassessed in partnership with families. Where multi-agency interventions are in place regular co-ordinated meetings should take place and where necessary concerns may be escalated
https://www.safeguarding-bathnes.org.uk/sites/default/files/lsab.lscb_escalation_protocol_.pdf

| Need / Risk | | Assessment | Impact / Response |
|---|---|---|---|
| Level 1 | Child, YP or family whose needs are being met, or whose needs can be met by universal services | **Universal Services** | At this level, needs are met by parents, carers, communities and universal services for example GP, HV, SN, Education, Children's Centres etc. Please visit One Big Database Bathnes and/or Wellbeing Options for further information regarding universal services. |
| Level 2 Universal + | Child, YP or family with additional needs that can be met by a single agency or by signposting to an additional agency | **Consider an (Early Help Assessment EHA)** | Consider using the EHA as a way to identify needs and plan a response, either single agency or with the support of another agency. Details of which can be found via the Early Help App.<br>You may consider contacting your safeguarding lead within your agency for further support and guidance at this level.<br><br>Signpost to Rainbow Resource / SEND local offer or the NHS Safeguarding APP to identify types of support including local resources. |
| Level 3 | Child, YP or Family that needs a co-ordinated programme of support from more than one agency | **Complete an Early Help Assessment (EHA)** | Undertake an EHA to identify evidence of the level of need and to plan a holistic multi-agency response. This should be done with parental consent via a Team Around the Family (TAF) meeting co-ordinated by the nominated lead professional. This should be done in partnership with the family so they fully understand the purpose and benefits of engaging and that the aim is to be supportive. You may wish to discuss with your safeguarding lead if the family refuse consent. |
| Level 4 | Child, YP or family who require intensive and co-ordinated support for complex issues via targeted services/ Early Help and /or where support at Level 3 has not improved outcomes | **An Early Help Assessment has been completed but not outcomes have not improved** | The need/risks have not been met / addressed by the multi-agency action plan in place following EHA. The child, YP or family may require long term intervention from statutory and specialist services. |
| S.17 Child in Need<br>Level 5 | Child or Young Person at risk of /or suffering significant harm due to compromised parenting, or whose needs require acute services or care away from their home | **Statutory / Specialist Assessment** | **If a child is in immediate danger, ring the Police.** Otherwise refer urgently to the Duty Team on **01225 396312** or **01225 396313,** or, outside office hours, the Emergency Duty Team on **01454 615165.**<br><br>You should follow up the referral in writing within 48 hours. |

## Levels of Need/Risk and Impact

| **Level 1: Universal - No Risk (this provides a baseline for what all children and young people should expect)** | |
|---|---|
| **Food** | Child is provided with appropriate quality of food and drink, which is appropriate to their age and stage of development any special dietary requirements are always met |
| **Quality of housing** | Accommodation has all essential amenities such as heating, shower, cooking facilities, adequate beds and bedding and a toilet and is in a reasonable state of repair and decoration. |
| **Stability of housing** | Child has stable home environment without too many moves (unless necessary) |
| **Child's Clothing** | Child is dressed appropriately for the weather clothing is clean and appropriate for the child's age |
| **Animals** | Animals are well cared for and do not present a danger to children or adults |
| **Hygiene** | The child is clean and is either given a bath/washed daily, teeth brushed and any skin conditions treated appropriately |
| **Safe sleeping arrangements and co-sleeping for babies** | There is suitable bedding and sleeping arrangements carers have an awareness of the importance of room temperature, sleeping position of the baby and carer does not smoke in household |
| **Seeking advice and intervention** | Mother seeking appropriate access to maternity services in pregnancy.<br>Advice sought from professionals/ experienced adults on matters of concern about child's health, dental/optical and all immunisations are up to date. |
| **Disability and illness** | Carer complies with needs relating to child's disability |
| **Safety awareness and features** | Evidence of safety awareness, equipment use and maintenance |

| | |
|---|---|
| **Supervision of the child** | Appropriate supervision is provided in line with age and stage of development |
| **Handling of baby/response to baby** | Carer is attuned to their baby, spends time, cooing and smiling, holding and behaving warmly |
| **Care by other adults** | Never in sole Care of an under-16. Parent /child always aware of each other's whereabouts |
| **Responding to adolescents** | Adolescents' needs addressed appropriately, where risky behaviour occurs it is identified and responded to appropriately by the carer |
| **Parent/carer's attitude to child, warmth and care** | Carer responds appropriately if child distressed or hurt and understands the importance of consistent demonstrations of love and care |
| **Child's emotional wellbeing** | The Child engages in age appropriate activities and displays age appropriate behaviours, child has a positive sense of self and resilience |
| **Sexual Relationships** | The Child / Young Person demonstrates healthy sexual and emotional relationships and has a stable friendship group |
| **Boundaries** | Carer provides consistent boundaries and ensures child understands how to behave and to understand the importance of set limits |
| **Adult arguments and violence** | Carers do not argue aggressively and are not physically abusive in front of the children |
| **Physical Abuse** | The child is chastised appropriately using positive reinforcement and ignoring misdemeanours. Withdrawal of 'treats' are proportionate to the misdemeanour |
| **Positive Values** | Carer encourages child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness |
| **Substance Abuse** | Carer does not misuse drugs or alcohol |

**LEVEL 2:**

| **Risk Level 2** | **Impact** |
|---|---|
| **Food** | |
| Child is provided with reasonable quality of food and drink and seem receive an adequate quantity for their needs, but there is a lack of consistency in preparation and meeting special dietary requirements | Potential for malnourishment and ill health if consistency of diet not maintained. Support from single agency advice accepted and support welcomed |
| **Quality of housing** | |
| Accommodation is in need of decoration and requires repair and may also be damp.<br>Carer recognises the importance of the home conditions to the child's sense of well-being, but is hampered by personal circumstances. | Increased risk of asthma and increased risk of accidents. With support from single agency in the main is able to overcome personal circumstances and has plans for improvement |
| **Stability of housing** | |
| Child has experienced house moves/ new adults in the family home. | New adults may pose a threat, the instability causes distress to child and insecurity. Loss of friends and familiarity for child |
| **Child's Clothing** | |
| Child has clothes which are appropriate, but are sometimes poorly fitting, unclean and crumpled. Although carer is aware. their own personal circumstances can get in the way of providing for the child's needs | Child feels awkward and is teased, clothes are uncomfortable impacts on emotional health. With support able to prioritise child's clothing and organise to ensure clothing is clean and ironed |
| **Animals** | |
| Animals look reasonably well cared for, and present no obvious risk, however, contribute to a sense of chaos in the house. | Child's needs are not met as so much chaos in home. Minimal impact require advice on pet care and risk re: health and safety but can be met through local support |
| **Hygiene** | |
| The child is reasonably clean, but the carer does not bath/wash the child regularly and/or the child is not consistently encouraged to do so in an age appropriate way.<br>Teeth not always cleaned, recurrent nappy rash, skin conditions inconsistently managed. | Child is dirty and smelly, teeth are rotting and lead to loss of teeth and increased risk of disease, Through support and role modelling situation improving |

| Risk Level 2 | Impact |
|---|---|
| **Safe sleeping arrangements and co-sleeping for babies** | |
| Carer aware of the dangers of co-sleeping and recognises the dangers of drugs and alcohol by the carer, but this is sometimes inconsistently observed. Do not follow SIDs /SUDI advice, smoking in home, and sleeping arrangements for children can be a little chaotic | Potential for cot death and for older children spreading diseases head lice and other contagious skin and respiratory conditions. Carers attend support groups and health education sessions facilitated by support agency. Results in improved consideration given to sleeping arrangements in the home |
| **Seeking advice and intervention** | |
| Mother not attending all routine antenatal appointments.<br>Delay in seeking advice about illnesses, Child WNB to routine dental, optical and immunisation appointments.<br>Immunisations are delayed, but eventually completed. | Potentially puts the unborn baby at risk, and failure to identify conditions that can be identified routinely<br>Increased risk of significant ill health and visual loss will impact on learning With support attending routine appointments, support given to manage range of commitments and manage daily routine |
| **Disability and illness** | |
| Personal circumstances get in the way of meeting child's disability needs. Carer not proactive in seeking advice and help | Support from single agency in caring for a child with a disability leads to better understanding and ability to pro-actively consider needs |
| **Safety awareness and features** | |
| Inconsistent in use and maintenance of safety equipment, and allows personal circumstances to get in the way | Minor injuries and incidents continue support offered with safety equipment and noticed improvement of use |
| **Supervision of the child** | |
| Variable supervision is provided both indoors and outdoors, but carer does intervene where there is imminent danger. | Child suffers unnecessary accidents and injuries, at risk of grooming, and risk from others. Safety and danger awareness reinforced by working with single agency results in improved supervision |
| **Handling of baby/response to baby** | |
| Carer is not always consistent in their responses to the baby's needs, as their own circumstances get in the way of responding to the child's | Inappropriate hard wiring of the brain. Support given to raise awareness of baby's developmental needs as they grow enabling carers to pre-empt behaviours. Examples given of appropriate handling and responsiveness |
| **Care by other adults** | |
| Carer aware of the importance of safe care, but sometimes is inconsistent because of own personal circumstances | Increased likelihood of harm to child. Raised awareness of the impact at developmental ages of care needs to ensure baby safe and needs are met |

| Risk Level 2 | Impact |
|---|---|
| **Responding to adolescents** | |
| Carer is aware of the adolescent's needs but is inconsistent in responding to them. | Adolescent misunderstood resulting in range of inappropriate behaviours which impact negatively on emotional health. Support and education required to understand adolescent behaviour and needs |
| **Parent/carer's attitude to child, warmth and care** | |
| Carer talks kindly about the child and is positive about achievements most of the time but allows their own difficulties to impact.<br>Carer recognises praise and reward are important but is inconsistent in this.<br>Child not always listened to and carer is angry if child seeks comfort through negative emotions such as crying. Does not always respond appropriately if child distressed or hurt. Carer understands the importance of demonstrations of love and care, but own circumstances and difficulties sometimes get in the way of providing these<br>Parents/carers lack emotional warmth and can be overly critical<br>Parents level of anxiety is disproportionate to the concerns expressed | Inconsistent parenting, poor attachment, inappropriate responses leaving child confused with potential impact on hard wiring of the brain.<br>Carers unable to demonstrate warmth and care appropriately, require support to gain insight and strategies to manage.<br>Child or young person has little self-worth and critical of self and others<br>The child or young person is exhibiting anxiety in response to parental anxiety |
| **The child's emotional wellbeing** | |
| The child has a negative sense of self and abilities which is not identified by carers | Child is at risk of becoming involved in negative behaviour/ activities |
| **Sexual Relationships** | |
| Parents set inconsistent appropriate boundaries with regard to relationships including online access | Child or young person has sense of lack of privacy and s unable to express their anxieties with regard to relationships due to inconsistent messages. In appropriate use of language . Over friendly with strangers |
| **Boundaries** | |
| Carer provides inconsistent boundaries and uses mild physical and moderate other sanctions | Child feels insecure, loss self-worth, child distressed by inconsistent parenting response. Parenting courses provide education and support to parent more effectively and gain insight into behaviours at different stages of development |

| Risk Level 2 | Impact |
|---|---|
| **Adult arguments and violence** | |
| Carers sometimes argue aggressively in front of children, but there is no physical abuse of either party | Research evidence of negative impact of witnessing abuse. Support to understand the impact of witnessing aggressive verbal abuse on children results in reduction in frequency |
| **Physical abuse** | |
| Child displays behaviour that indicates they are subject to physical threats of behaviours | Fearful of parents, noticed to have animal / insect bites , aggressive behaviour at school/college/play school |
| **Positive Values** | |
| Carer inconsistent in helping child to have positive values. Carer aware of need to monitor child watching inappropriate material and playing inappropriate computer games, but is inconsistent in monitoring because of own personal difficulties and circumstances. | No appropriate role model and so child feels confused by experiences and acts out. Supported by single agency to understand the importance of instilling positive values and recognising what is inappropriate |
| **Substance misuse** | |
| The carer believes it is normal for children to be exposed to regular alcohol and substance use.<br>The mood of the carer can be irritable or distant at times. | Child grows up to repeat behaviour of parents putting them at risk of infection, liver damage, grooming and county lines involvement. Child distressed by inconsistent mood of Carer resulting in low self-esteem/self-worth.<br>Work with support worker to recognise impact of exposure to alcohol and substance misuse and also insight into the carers' behaviours and moods. Providing strategies to manage in partnership with? |

**LEVEL 3:**

| **Risk Level 3** | **Impact** |
|---|---|
| **Food** | |
| Child is provided with reasonable quality of food and drink and seem receive an adequate quantity for their needs, but there is a lack of consistency in preparation and meeting special dietary requirements | Carer continues to be inconsistent in preparation of meals, child's weight not maintained or growing concerns for obesity. Specialist diets not maintained and so impacting on health |
| **Quality of housing** | |
| Accommodation is in need of decoration and requires repair and may also be damp.<br>Carer recognises the importance of the home conditions to the child's sense of well-being, but is hampered by personal circumstances.<br>Lack of preparation for a new baby in the antenatal period. | Personal circumstances overwhelm. Ongoing concerns with regard to housing impacting on family. Resulting in increased likelihood of ill-health and accidents<br><br>Newborn baby's needs are not met and can put them at risk |
| **Stability of housing** | |
| Child has experienced house moves/ new adults in the family home. | Frequency of new adults in the home appears to be increasing and at risk of homelessness which will have negative impact on child's security |
| **Child's Clothing** | |
| Child has clothes which are appropriate, but are sometimes poorly fitting, unclean and crumpled. Although carer is aware. their own personal circumstances can get in the way of providing for the child's needs. | In spite of additional support child's clothing continues to be unclean and ill-fitting, leading to bullying and distress |
| **Animals** | |
| Animals look reasonably well cared for, and present no obvious risk, however, contribute to a sense of chaos in the house. | Animals have no boundaries on their behaviour, house smells and they are rarely exercised so have boundless energy and frustration which potentially puts children at risk |
| **Hygiene** | |
| The child is reasonably clean, but the carer does not bath/wash the child regularly and/or the child is not consistently encouraged to do so in an age appropriate way.<br>Teeth not always cleaned, recurrent nappy rash, skin conditions inconsistently managed. | Children are increasingly dishevelled, recurrent bouts of head lice and skin conditions. Teeth are rotting and refuse to attend the dentist, or make false claims about doing so |

| Risk Level 3 | Impact |
|---|---|
| **Safe sleeping arrangements and co-sleeping for babies** | |
| Carer aware of the dangers of co-sleeping and recognises the dangers of drugs and alcohol by the carer, but this is sometimes inconsistently observed. Do not follow SIDs / SUDI advice, smoking in home, and sleeping arrangements for children can be a little chaotic. | Carers continue to smoke and consume alcohol whilst co-sleeping with baby. Baby observed to be overdressed and placed on front in cot and pram |
| **Seeking advice and intervention** | |
| Mother missing routine antenatal appointments/not engaging with advice in the antenatal period e.g. smoking cessation.<br><br>Delay in seeking advice about illnesses, Child WNB to routine dental, optical and immunisation appointments.<br>Immunisations are delayed, but eventually completed | Risks to the unborn not identified, lifestyle behaviours could adversely impact on the unborn's health<br><br>Continues **not** to bring child/ren to appointments which is having a detrimental effect on their health. Carer does not appear to understand the seriousness of this for the child/ren. |
| **Disability and illness** | |
| Personal circumstances get in the way of meeting child's disability needs. Carer not proactive in seeking advice and help | Carers own needs continue to come before those of the child. Unable to prioritise for a number of reasons |
| **Safety awareness and features** | |
| Inconsistent in use and maintenance of safety equipment, and allows personal circumstances to get in the way | Safety equipment not used consistently, children at risk of injuries, Carers unable or willing to act on advice |
| **Supervision of the child** | |
| Variable supervision is provided both indoors and outdoors, but carer does intervene where there is imminent danger. | Children at risk of hurting themselves as carers continue to put own needs first and do not provide the supervision necessary to keep children safe |
| **Handling of baby/response to baby** | |
| Carer is not always consistent in their responses to the baby's needs, as their own circumstances get in the way of responding to the child's | Carers unable to be consistent in handling of baby, leading to baby having mixed messages. Baby appears fearful and attachment appears to be lacking |
| **Care by other adults** | |
| Carer aware of the importance of safe care, but sometimes is inconsistent because of own personal circumstances | Carers needs for attention, affection etc come first. Baby left neglected emotionally and physically for long periods |

| Risk Level 3 | Impact |
|---|---|
| **Responding to adolescents** | |
| Carer is aware of the adolescent's needs but is inconsistent in responding to them. | Adolescents increasingly involved in risky behaviour, missing on occasions, staying out late and disrespectful to carers |
| **Parent/carer's attitude to child, warmth and care** | |
| Carer talks kindly about the child and is positive about achievements most of the time but allows their own difficulties to impact.<br>Carer recognises praise and reward are important but is inconsistent in this.<br>Child not always listened to and carer angry if child seeks comfort through negative emotions such as crying. Does not always respond appropriately if child distressed or hurt. Carer understands the importance of demonstrations of love and care, but own circumstances and difficulties sometimes get in the way of providing these<br>Parent/Carer has high levels of anxiety | In spite of support and advice unable to put child's needs first, through inconsistent parenting. Resulting in child showing signs of distress, poor attachment, fearful and behavioural challenges. Lack emotional support<br><br>The Parent /Carer's anxiety is beginning to impact on the child's wellbeing in that they are unable to socialise or behave like peers. |
| **The child's emotional wellbeing** | |
| The child has a negative sense of self and abilities and suffers with low esteem which makes them vulnerable to peers and adults | Child is involved in negative behaviour/activities, non-educational attendance, may be excluded at increased risk of grooming and exploitation |
| **Sexual Relationships** | |
| Parents set no boundaries with regard to relationships including online access. Parents /Carers allow access to inappropriate social media, and child or young person witness to inappropriate sexual behaviour | Friendships and relationships inappropriate for age . Young person appears fearful, exhibiting interest in other risky behaviours e.g. alcohol, substance misuse . Secondary enuresis/encopresis. Sharing images online Unsafe sexual behaviour albeit reported to be consensual . compulsive masturbation |
| **Boundaries** | |
| Carer provides inconsistent boundaries and uses mild physical and moderate other sanctions | Carers unable to be consistent in boundaries leading to frustration and at times disciplining inappropriately. Child responds to inconsistency with increasing levels of challenging behaviour |

| Risk Level 3 | Impact |
|---|---|
| **Adult arguments and violence** | |
| Evidence shows that verbal and domestic abuse can adversely impact on the unborn<br><br>Carers sometimes argue aggressively in front of children, but there is no physical abuse of either party<br>Family environment is volatile and unstable, intolerant critical and inconsistent. | Stress in utero can result in increased cortisol levels which impacts on the neurological development of the unborn brain.<br><br>Neither carer is able to respond appropriately. The frequency and duration of verbal abuse is increasing. Children are showing signs of distress and mimicking behaviour at Nursery/School/ College<br>Child or young person becomes vulnerable to grooming and exploitation as they lack positive self-worth |
| **Physical Abuse** | |
| Child displays behaviour that indicates they are subject to physical threats or behaviours Parents not seeking medical advice when child has been exposed to harmful substances | Fearful of parents, repeated disclosures by child with no evidence appears to mirror adult behaviour in the playground. Injuries as a result of being exposed to harmful substances |
| **Positive Values** | |
| Carer inconsistent in helping child to have positive values. Carer aware of need to monitor child watching inappropriate material and playing inappropriate computer games, but is inconsistent in monitoring because of own personal difficulties and circumstances. | Carers continue to watch inappropriate material in front of children. Carer unable to challenge partner due to own circumstances. Child exhibiting inappropriate behaviour |
| **Substance misuse** | |
| The carer believes it is normal for children to be exposed to regular alcohol and substance use.<br>The mood of the carer can be irritable or distant at times.<br>Mother continues to use substances throughout her pregnancy. | Carers continue to use alcohol and drugs in front of the children.<br>Continue to normalise their behaviour and will not listen to others.<br>Carers lack any insight into their behaviour and the distress it causes to the child<br>The misuse of drugs and alcohol can result in foetal alcohol syndrome and greater risk of health related concerns for the unborn. |

**LEVEL 4:**

| **Risk Level 4** | **Impact** |
|---|---|
| **Food** | |
| Child appears hungry.<br>Children's special dietary requirements are rarely met and the carer is indifferent to the importance of appropriate food for the child | Child loses weight, unable to concentrate at school/college, clothes are increasingly ill-fitting. Health affected by inappropriate diet |
| **Quality of housing** | |
| Little or no preparation for a new baby in the antenatal period.<br>The accommodation is in a state of disrepair, carers are unmotivated to address this and the child has suffered accidents and potentially poor health as a result; the whole environment is dirty and chaotic | Unsafe environment for new-born baby.<br>Child's health deteriorates as a result of the insanitary conditions at home. Child unable to bring friends home as too embarrassed by their home circumstances. Child bullied at school/ college because they smell, of such as smoke, body odour, urine and faeces |
| **Stability of housing** | |
| Child does not have a stable home environment, and has either experienced lots of moves and/or lots of adults coming in and out of the home for periods of time | Child feels increasingly insecure by frequency of moves, loss of friends and family.<br>Possible witness to inappropriate behaviour by the adults coming to the home. Possible drug dealing/cuckooing |
| **Child's Clothing** | |
| Child has clothing which is dirty and crumpled, in a poor state of repair and not well fitting. The child lacks appropriate clothes for the weather and does not have sufficient clothing to allow for regular washing | Child is bullied at school/ college, clothes smelly and dirty child gets more illnesses due to inappropriate clothes for weather, Impact on child's self-esteem and self-worth |
| **Animals** | |
| Presence of faeces or urine from animals not treated appropriately and animals not well trained and the mistreatment of animals by adults or children is not addressed. | Risk of disease and ill health from unhygienic practices. Children brought up to consider mistreatment of animals is normal. Children could be very distressed by the mistreatment which impacts on emotional health and well-being |
| **Hygiene** | |
| Carers do not take an interest in child's appearance and do not acknowledge the importance of hygiene to the child's wellbeing. Frequent head-lice and nappy rash; and evidence teeth not cleaned. | Child bullied at school/college, self-worth and self –esteem impacted on negatively. Clothes and hair smell, dental decay |

| Risk Level 4 | Impact |
|---|---|
| **Safe sleeping arrangements and co-sleeping for babies** | |
| Carer ignores advice about beds and bedding, room temperature, sleeping position of the baby and smoking. Sleeping arrangements are not suitable and carer is indifferent to advice regarding this or impact on child | Baby becomes over heated or smothered by Carers but Carers still refuse to listen to advice |
| **Seeking advice and intervention** | |
| Mother persistently failing to attend for antenatal care.<br><br>The carer does not routinely seek advice about childhood illnesses but does when concerns are serious or when prompted by others. Child WNB routine appointments<br>. | Unborn baby at risk due to mother's failure to attend antenatal appointments<br>Carer continues to listen to advice and acts when prompted but is not pro-active in meeting child's needs. Child suffering unnecessary |
| **Disability and illness** | |
| Carer shows anger and frustration at child's disability. Often blaming the child and not recognising identity | Child's emotional health impacted on negatively, feels they are in the way and unloved. Poor sense of self-worth leading to poor achievements |
| **Safety awareness and features** | |
| The carer does not recognise dangers to child and there is a lack of safety equipment, and evidence of daily dangers to the child | Child comes to harm frequently, multiple attendances at Emergency Department (ED) for minor injuries |
| **Supervision of the child** | |
| Lack of concern about where child is or who they are with and the carer is inconsistently concerned about lack of return home or late nights | Child out late at night, Carers don't know who they are with, behaviours change, frequently wearing new clothes and has more material objects e.g. mobiles, trainers. All indicate suspicion of being groomed. Younger children playing unsupervised at risk of physical harm |
| **Handling of baby/response to baby** | |
| Carer does not recognise the importance of responding consistently to the needs of the baby | Baby and Mother not attuned leading to Carer not being able to recognise baby's needs. Baby's needs not me and could result in poor feeding, nappy rash and emotional distress |

| Risk Level 4 | Impact |
|---|---|
| **Care by other adults** | |
| Carer is indifferent to the importance of safe care of the child and leaves the child with unsuitable or potentially harmful adults and does not recognise the potential risks to the child | Child is at risk of harm by others, may be at risk of physical or sexual harm. Child feels must accept situation as carer has left them with the person who is trusted by their carers |
| **Responding to adolescents** | |
| The carer does not consistently respond to the adolescent's needs and recognises risky behaviour but does not always respond appropriately<br>***NOTE** Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools, colleges and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. | Adolescent at risk of Child Sexual Exploitation and Child Criminal Exploitation as they manage the challenges of puberty. Adolescent becomes confused as responses to them are inconsistent |
| **Parent/carer's attitude to child, warmth and care** | |
| Unwanted pregnancy, mother ambivalent towards pregnancy expressing lack of bonding with inborn baby.<br><br>Carer does not speak warmly about the child and is indifferent to the child's achievements.<br>Carer does not provide praise or reward and is dismissive of praise from others.<br>Emotional response is sometimes brisk or flat and lacks warmth and can be aggressive or dismissive if child distressed or hurt.<br>Parent has high levels of anxiety regarding the child | Significant risk that mother will be unable to bond with baby resulting in long term impact on the baby's emotional health and well-being. Additional risk of post-natal depression<br><br>Child feels unloved and uncared for, poor attachment. Low self –esteem and self-worth leading to behaviours to make sense of Carers reactions to them<br>The parents high anxiety results in child being removed from school/college unnecessarily or prevented from playing sport or socialising |
| **The child's emotional wellbeing** | |
| The child has a negative sense of self and abilities and suffers with low esteem parents and carers are not emotionally supportive | Child is involved in negative behaviour/activities, is being encouraged by peers to engage in self-destructive anti-social or criminal behaviour. |

| Risk Level 4 | Impact |
|---|---|
| **Sexual Relationships** | |
| Parents unable to manage child/young person's behaviour. Parents /Carers allow access to inappropriate social media, and child or young person witness to inappropriate sexual behaviour. Frequent unknown adult visitors to home | Friendships and relationships inappropriate for age. At risk of exploitation and grooming, frequently missing from home and school/college. Frequent changes in friendship groups. |
| **Boundaries** | |
| Carer provides few boundaries, and is harsh and critical when responding to the child's behaviour and uses physical sanctions and severe other sanctions | Physical abuse can lead to both physical and emotional harm. As boundaries are inconsistent the impact for the child would be one of confusion |
| **Adult arguments and violence** | |
| Risk to unborn / new-born baby due to domestic abuse within the relationship.<br><br>Carers frequently argue aggressively in front of children and this leads to violence. Consistent hostility and /or rejection, attributing negative and belittling characteristics on the child or young person. | Risk of miscarriage, premature labour, stillbirth and impact on the neurological development of the vulnerable new born baby.<br>Fear and sense of protection to the Carer leading to either normalising of behaviour or a child that is afraid impacting on the hard wiring of their brain<br>Child or young person feels unsafe, has no positive role model, feels protective of the victim of domestic abuse which is impacting on them socially and educationally |
| **Physical Abuse** | |
| Child displays behaviour that indicates they are subject to physical threats or behaviours Evidence of bite /teeth marks; burns; bruising, injuries that cannot be accounted for | Child or young person exhibits angry behaviour, peer to peer abuse or sibling abuse. Child or young person fearful, self-harm, expressing suicidal ideation. |
| **Positive Values** | |
| Carer does not monitor the watching of inappropriate materials or playing inappropriate games and is indifferent about the impact on the child. Carer does not teach child positive values | Child witnessing behaviours that are developmentally inappropriate, this may result in them acting out some of the behaviours. May impact on them normalising what they see. Sense of loneliness if unable to share with peers. Inappropriate play |
| **Substance misuse** | |
| Mother continues to use substances throughout her pregnancy and is not engaging with support services.<br><br>The carer's use leads to an inconsistency in caring and the child takes on inappropriate responsibilities at home | Potential withdrawal for new born baby. Long term effects on child's development post birth.<br>The child is unable to mix with peers as has to take responsibility for younger siblings/ carers. Educational achievement is affected by missing days at school/college. Sense of missing out with peers |

**LEVEL 5:**

| **Risk Level 5** | **Impact** |
|---|---|
| **Food** | |
| Child appears hungry.<br>Children's special dietary requirements are rarely met and the carer is indifferent to the importance of appropriate food for the child | Child requires acute intensive care and clear that the child has suffered significant harm and is at risk of further harm |
| **Quality of housing** | |
| Little or no preparation for a new baby in the antenatal period.<br><br>The accommodation is in a state of disrepair, carers are unmotivated to address this and the child has suffered accidents and potentially poor health as a result; the whole environment is dirty and chaotic | Unsafe environment for new born baby, with the potential for significant harm<br>.<br>Child is missing from home, poor attendance at school/college, increasingly risky behaviours, younger children develop secondary enuresis<br>. |
| **Stability of housing** | |
| Mother has no suitable housing to return to following the birth of baby.<br>Child does not have a stable home environment, and has either experienced lots of moves and/or lots of adults coming in and out of the home for periods of time | New born baby at risk of significant harm from lack of shelter, warmth illness and infection.<br><br>Child at risk of being drawn into inappropriate situations so as to fit in. Signs of significant harm including behavioural, poor educational achievement, self-harm , poor emotional health and well-being |
| **Childs Clothing** | |
| Child has clothing which is dirty and crumpled, in a poor state of repair and not well fitting. The child lacks appropriate clothes for the weather and does not have sufficient clothing to allow for regular washing | Child starts to avoid school/ college, becomes withdrawn. Withdraws from previous interests. Increasing disharmony at home all signs of significant impact on child. May be groomed as response to wanting to fit in |
| **Animals** | |
| Presence of faeces or urine from animals not treated appropriately and animals not well trained and the mistreatment of animals by adults or children is not addressed. | Child encouraged to participate in mistreatment, is teased for showing concern. Child showing signs of distress in behaviour and presentation |

| Risk Level 5 | Impact |
|---|---|
| **Hygiene** | |
| No suitable area for preparation of new born baby's feeds and hygiene needs.<br>Carers do not take an interest in child's appearance and do not acknowledge the importance of hygiene to the child's wellbeing.<br>Frequent head-lice and nappy rash; and evidence teeth not cleaned. | Potential for new born baby to become seriously unwell.<br><br>Child has to have significant numbers of teeth removed. Teased because no longer able to speak properly. Loses weight as unable to eat. Increasingly negative impact on emotional health leading to self-harm, risk of being groomed |
| **Safe sleeping arrangements and co-sleeping for babies** | |
| Carer ignores advice about beds and bedding, room temperature, sleeping position of the baby and smoking. Sleeping arrangements are not suitable and carer is indifferent to advice regarding this or impact on child | Baby has sleep apnoea, frequent admissions to hospital. Carers refuse to listen to advice and sleeping arrangements remain the same |
| **Seeking advice and intervention** | |
| Concealed/denied pregnancy and mother not accessing any antenatal care.<br>The carer does not routinely seek advice about childhood illnesses but does when concerns are serious or when prompted by others.<br>Child WNB routine appointments | Potential for significant harm as no preparation for birth or new born baby's arrival.<br>Child hood illnesses not identified leading chronic presentation or acutely ill child. Carers not listening to advice |
| **Disability and illness** | |
| Carer shows anger and frustration at child's disability. Often blaming the child and not recognising identity | Child with disability is not meeting expected outcomes, carers not co-operating with treatment plans, resulting in significant harm to the child |
| **Safety awareness and features** | |
| The carer does not recognise dangers to child and there is a lack of safety equipment, and evidence of daily dangers to the child | Injuries increasing severity and frequency. Carers not taking advice and at significant risk |

| Risk Level 5 | Impact |
|---|---|
| **Supervision of the child** | |
| Lack of concern about where child is or who they are with and the carer is inconsistently concerned about lack of return home or late nights | Evidence through association of child or young person being at risk of grooming, known to be mixing with 'County Lines' groups and/or CSE rings. Younger children at risk from traffic hazards as found wandering in street late at night |
| **Handling of baby/response to baby** | |
| Carer does not recognise the importance of responding consistently to the needs of the baby | Child is showing signs of poor attachment, stays out late, reported missing, self-harming, educational achievement poor. Low self-esteem |
| **Care by other adults** | |
| Carer is indifferent to the importance of safe care of the child and leaves the child with unsuitable or potentially harmful adults and does not recognise the potential risks to the child | Child discloses significant harm |
| **Responding to adolescents** | |
| The carer does not consistently respond to the adolescent's needs and recognises<br>risky behaviour but does not always respond appropriately<br>***NOTE** Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. | Adolescent at risk of Child Sexual Exploitation and Child Criminal Exploitation and puts self at significant harm in attempt to find identity and sense of self-worth. Additional risk of self-harm in a variety of forms e.g. substance misuse, self-harm and anorexia nervosa |
| **Parent/carer's attitude to child, warmth and care** | **Impact** |
| Mother expressing concerning feelings towards unborn baby.<br><br>Carer does not speak warmly about the child and is indifferent to the child's achievements.<br>Carer does not provide praise or reward and is dismissive of praise from others.<br>Emotional response is sometimes brisk or flat and lacks warmth and can be aggressive or dismissive if child distressed or hurt.<br><br>The Parent/Carer displays high levels of anxiety. | Potential for significant impact on baby's physical and emotional wellbeing due to lack of attachment/bonding.<br><br>Child is at risk of carrying out self-harming behaviours or putting themselves in known dangerous situations.<br>The parent /carer's high level of anxiety is significantly harming the child's development e.g. social isolation, poor attendance at school/college or fabricating/inducing illness. |

| Risk Level 5 | Impact |
|---|---|
| **The child's emotional wellbeing** | |
| The child has a negative sense of self and abilities and suffers with low esteem parents and carers are not emotionally supportive and child is no longer meeting expected outcomes | Child's development is being significantly impaired, there is evidence of exploitation by others and there is evidence of self-harm. Child may be permanently excluded from school/college. |
| **Sexual Relationships** | |
| Relationships with known criminals or paedophiles. Frequently staying out. Using drugs and alcohol excessively . Pregnant refusing to disclose father. Has goods and money unable to account for. Fearful of members of the family refuses to disclose and is protective. Parents and Carers feel out of control. | Sexual activity in exchange for goods, Groomed and at risk of CSE and County Lines. Risk of rape, may request termination and present alone or with someone who will not leave her and answers for her. Frequent and excessive self-harm / overdose. Present extreme behaviour and violence which is out of character. STI's and UTI's. May disclose abuse |
| **Boundaries** | **Impact** |
| Carer provides few boundaries, and is harsh and critical when responding to the child's behaviour and uses physical sanctions and severe other sanctions | Escalating levels of physical chastisement puts the child at significant risk of harm or disclosure by child leads to evidence of significant harm occurred |
| **Adult arguments and violence** | |
| Risk to unborn/new born baby due to domestic abuse within the relationship.<br><br>Carers frequently argue aggressively in front of children and this leads to violence. | Risk of miscarriage, premature labour, stillbirth. Risk of significant physical/emotional harm to new born baby.<br>Child that is at risk of significant emotionally and also at risk of physical harm by becoming involved in the abuse<br>Child or young person has suffered long term neglect of their emotional needs due to family environment and is now at high risk of or is already involved in sexual or criminal exploitation either as a perpetrator or victim |
| **Physical Abuse** | |
| Child displays behaviour that indicates they are subject to physical threats or behaviours Evidence of bite /teeth marks; burns; bruising, fractures, (including old fractures) injuries that cannot be accounted for. Parents /Carers deliberately exposing child to risk , corporal punishment, exposing to environment too cold /hot ; giving un-prescribed medication/illegal drugs | Child or young person exhibits angry behaviour, peer to peer abuse or sibling abuse. Child or young person fearful , self- harm, expressing suicidal ideation and or taking overdoses, drinking excessively, substance misuse, injuries from drug paraphernalia; increasingly withdrawn, or extreme behaviours |

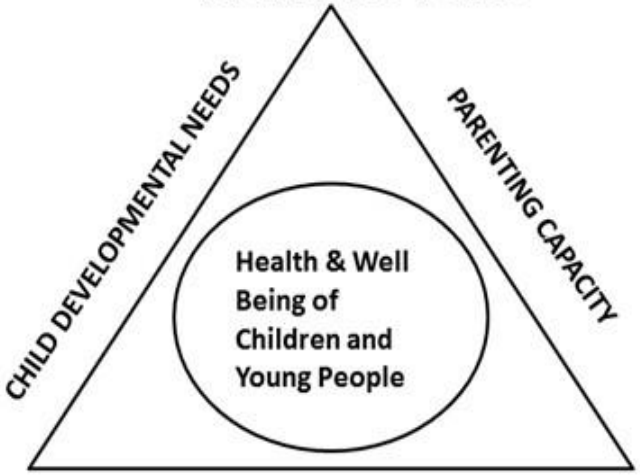
| Risk Level 5 | Impact |
|---|---|
| **Positive Values** | |
| Carer does not monitor the watching of inappropriate materials or playing inappropriate games and is indifferent about the impact on the child. Carer does not teach child positive values | Evidence of significant harm to child through disclosure or behaviour |
| **Substance misuse** | |
| Mother continues chaotic use of substances throughout her pregnancy, including street drugs and is not engaging with support services.<br>The carer's use leads to an inconsistency in caring and the child takes on inappropriate responsibilities at home | Risk of premature birth/low birthweight. High chance of withdrawal for new born baby as well as long term effects on child post birth.<br><br>Child unable to be a child due to responsibilities resulting in harm |

There are a number of Tools staff may find helpful these include the SBAR Communication Tool stands for Situation, Background, Assessment and Recommendation and can be found at Appendix 2

The Safer Communication Tool – Appendix 3
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/208132/NHS_Safer_Leaflet_Final.pdf is also a useful tool in assessing risk and promoting safety.

Risk and Protective Factors for Younger Children

# RISK FACTORS




- Irritable/sleepless child
- Child with additional needs/specific learning disabilities including ASD, Aspergers, or ADHD
- Child with communication difficulties
- Poor school attendance and attainment
- Low self-esteem/self harming
- Defiant/angry child
- Child affected by bereavement

- Mother under 20 years at first pregnancy
- Parent with history of poor school attendance and attainment
- Parent formerly "Looked After"
- Parent misuses substance or alcohol
- Parent with mental health difficulties
- Poor attendance at health appointments (GP, midwife, health visitor, clinic)
- Domestic abuse
- Parent with learning difficulties
- Parent with physical disability
- Parent affected by bereavement
- Previous children permanently removed from parent's care

## FAMILY & ENVIRONMENTAL NEEDS

- Single parent
- Serial relationships
- Reconstructed families (step parent/ children)
- Low income/or debt
- Out of work
- Frequent moves
- Homeless/ insecure housing
- Poor quality housing
- Uncertain immigration status
- Sleeping arrangements e.g. co-sleeping

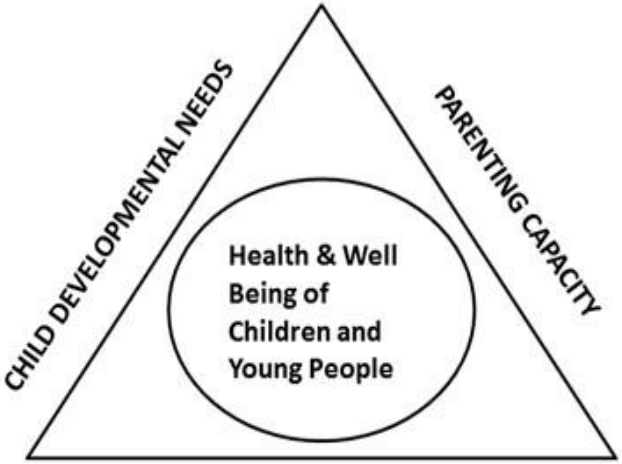
**KEY:**

High evidence risk

Medium evidence risk

# PROTECTIVE FACTORS

- Able bodied child with good health and positive development
- Calm child with positive attachment
- Good school attendance and attainment
- Child has secure relationships and able to express self verbally
- Good communication skills
- Calm and accepting child
- Acceptance of loss processes




- "Older Mother"
- Parent with good physical and mental health
- Controlled use of substances
- Positive attitude to education
- Family support
- Good attendance at health checks and other appointments
- Shared parental responsibility
- Parent with no additional needs
- Acceptance of loss process
- Attending Day Care

FAMILY & ENVIRONMENTAL NEEDS

- Stable relationships
- Positive contact with absent parent
- Stable and well managed income
- Employed
- Stable neighbourhood / community links
- Secure tenancy or owned occupier
- Positive acceptance of the child
- Housing meets decent housing standards

**KEY:**

High Evidence

Medium Evidence

Acknowledgement is given to Social Care Can Do Partners in developing the Risk Assessment Toolkit

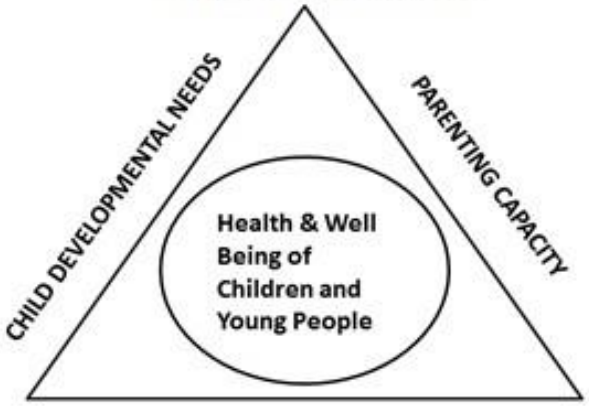
# RISK ASSESSMENT TOOLKIT

Risk and Protective Factors for **Young People**

Professor Munro has highlighted the uncertainty that pervades the work of child protection and the challenges for professionals in assessing risk and estimating the dangers facing a child/young person. This guidance is designed to assist practitioners when undertaking an assessment (e.g. CAF, Initial/Core Assessment, SEN) to evaluate the risk and protective factors to achieve the best outcomes for the child. The following risk and protective factors are based on research and findings from Serious Case Reviews. The protective interventions have been shown to alleviate some of the predicted negative outcomes for children by building resilience. If the risk factors are present in a family, and there are no corresponding protective factors, the evidence tells us that a high percentage of these children will have poor life outcomes (offending/mental ill health/repeat abuse/neglect as parents). As children get older, the influence from peers and the wider community exerts an increasing impact, both positive and negative.

## RISK FACTORS

- ADHD/hyperactivity
- Child with communication difficulties
- Early onset of coming to police attention
- Low intelligence
- Male
- Member of deviant peer group
- Peer rejected/child bullied
- Poor school attendance & attainment
- Child sexual exploitation/ absconding behavior
- Defiant/angry child




- Parent with history of offending
- Parent with history of poor school attendance and attainment
- Parent misuses substance or alcohol
- Parent with mental health difficulties
- Family/parent conflict
- Poor supervision/interest in child's activities
- Large number of siblings

**FAMILY & ENVIRONMENTAL NEEDS**

- Low income / or debt
- Out of work
- Frequent moves
- No engagement in non-deviant community activities
- Poor and high crime
- Drug abuse neighbourhood

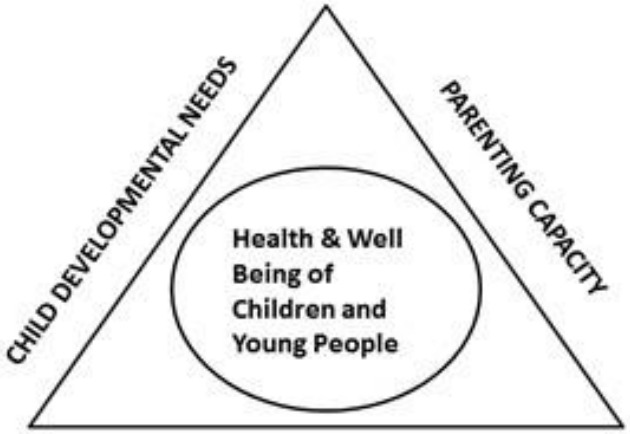
**Key**: *Need to review as not same level of evidence*

High Evidence Risk

Medium Evidence Risk

# PROTECTIVE FACTORS

- Calm child with positive attachment
- Good communication skills
- Female
- Positive peer relationships
- Child has secure relationships and able to express self verbally
- Good self-esteem and engagement with peers
- Good school attendance and attainment




FAMILY & ENVIRONMENTAL NEEDS

- Parent with good physical and mental health
- Positive regard for the young person
- Good supervision of the young person
- Non offending parents
- Positive attitude to education
- Family support

- Positive acceptance of child
- Citizenship /community links
- Stable neighbourhoods
- Good school with positive regard for young people
- Relationship with at least one trusted adult
- Meaningful activities
- Stable relationships

Key Code:

- High Evidence Protection
- Medium Evidence Protection

Acknowledgment is given the Social Care Can Do Partners in developing the Risk Assessment Toolkit.

# Appendix 1

Working Together to Safeguard Children (2018) sets out organisations responsibilities to safeguard and promote the welfare of children. It is statutory guidance and applies to all professionals who work with children

## Chapter One

### Assessing Need and Providing Help

*Chapter One sets out the importance of early help, referral, assessment and process details:*

- additions to early help focus include: gangs and organised crime groups, missing, drug and alcohol abuse, radicalisation, trafficking and exploitation
- guidance about information sharing and GDPR
- assessment of disabled children, young carers and young people in secure youth establishments added
- emphasis on contextual safeguarding
- specific health responsibilities added to strategy discussion guidance
- responsibility moving from LSCB's to safeguarding partners to monitor effectiveness of arrangements

## Chapter Two

### Organisational Responsibilities

*Chapter Two defines agencies responsibilities to safeguard and promote the welfare of children:*

- Section 11 duties for all agencies are unchanged
- emphasis on guidance applying in its entirety to all schools
- section added about responsibility of CCG to ensure provision of designated health professionals
- Children's Homes, MAPPA and sports clubs and associations added to Section 11 duty
- Safeguarding responsibilities emphasised for all professionals working in voluntary, charity, social enterprise and faith based organisations

## Chapter Three

### Multi-agency Safeguarding Arrangements

*Chapter Three sets out responsibilities for the three statutory safeguarding partners to develop new local safeguarding arrangements:*

- safeguarding partners are the Local Authority, Police and Clinical Commissioning Group (CCG)
- the partners have full and equal responsibility to establish effective safeguarding arrangements
- organisations named as Relevant Agencies are required to cooperate with the arrangements
- new arrangements must be published and be in place by September 2019
- new arrangements will replace current safeguarding board arrangements

## Chapter Four

### Improving Child Protection and Safeguarding Practice

*Chapter Four sets out the process for the safeguarding practice reviews (replacing Serious Case Reviews):*

- new National Child Safeguarding Review Panel has been established. Panel will receive all serious incident notifications from the local authority.
- the panel will identify cases which raise issues of national significance to be reviewed as national child safeguarding practice reviews
- safeguarding partners are responsible for identifying and commissioning local reviews
- an initial rapid review will be undertaken on all cases

## Chapter Five

### Child Death Reviews

*Chapter Five sets out the duty on the child death review partners to establish new arrangements to review child deaths:*

- Local Authority and CCG are the statutory Child Death Review Partners
- the partners are responsible for establishing child death review arrangements – these can be based on current child death overview arrangements
- our current arrangements are on a West of England basis and this can continue
- current arrangements continue until replaced by new arrangements which must be in place by September 2019

*Full document and more Information: https://www.safeguarding-bathnes.org.uk/children/local-safeguarding-children-s-board*

## SBAR Tool – Appendix 2

***Prior to a referral, ask yourself – Have I - ?***

- Assessed the child /unborn & documented findings?
- Documented existing risk factors or issues
- Found any evidence of substance abuse, domestic abuse, mental illness, chaotic lifestyle or missed appointments?
- Found any early help interventions taking place [ e.g. C Early Help Assessment (CAF)
- Discussed the situation with the child/unborn parents?
- Checked who else is in the household?
- A need to discuss the situation with other professionals e.g. GP or HV
- Updated myself with the child/unborn available recent health history?
- Knowledge of any siblings? Are they at risk too?
- Checked for allocated social worker? Discussed my concerns with them?

| | | |
|---|---|---|
| S | **SITUATION** | |
| | ➢ Who is the child / unborn? | |
| | ➢ What problem did they present with? | |
| | ➢ What were the reasons given for this? | |
| | ➢ Is the child and or their parents aware of this referral? | |
| B | **BACKGROUND** | |
| | ➢ Who did the child present with? | |
| | ➢ What is the relationship? | |
| | ➢ Who else lives in the household? | |
| | ➢ What are their social circumstances? | |
| | ➢ What is the child's demeanour like? | |
| A | **ASSESSMENT** | |
| | ➢ What is your assessment of Injury/ reason /cause / mechanism or history related to presentation? | |
| | ➢ How relatives behave /interact with child? | |
| | ➢ Known environmental factors of home safety / security or issues of sharing? | |
| | ➢ Evidence of substance / domestic abuse / mental illness / chaotic lifestyle / missed appointments? | |
| | ➢ Why considered at risk? [Factual evidence ] | |
| | ➢ Impact on the child? | |
| R | **RECOMMENDATION** | |
| | ➢ Immediate intervention whilst in trust [ ring 1st / follow-up report] | |
| | ➢ Requires further investigation under ***SECTION 47 of Children Act 1989*** | |
| | ➢ Referral to Social Care for Single Assessment | |
| | ➢ Discharged BUT requires follow-up in community (Early Help) | |
| | ➢ Info sharing purposes ONLY - No ACTION | |

## Appendix 3 – Safer Communication Tool

Department of Health

# SAFER communication guidelines

These are guidelines for communications between health visitors and local authority children's social care teams using the SAFER process when a child may be suffering or is likely to suffer significant harm*.

All verbal communications can be carried out using the SAFER process. It can also be used for 'no name consultations'. The use of SAFER will ensure a uniform approach to communicating the level of risk to a child/children.

## Section A:
## Prior to referral ask yourself these questions:

### Assessment

- Have I assessed the child and family and documented my findings? If not what is the source of my information?

### Evidence

- What is happening, or not, which is causing concern/or impacting on the safety of the child?
- Is there any evidence of mental illness, substance abuse, domestic abuse, a chaotic lifestyle or missed appointments?

### Actions

- Have I consulted my Local Safeguarding Children's Board (LSCB) interagency procedures?
- How do the child's needs meet the local threshold for referral (Working together, 2013 p.14)
- Is a Common Assessment Framework (CAF) in existence for this child/ren?
- Have I documented all existing risk factors or issues?
- Has the situation/referral been discussed with the child's parent(s)/carers, or would this put the child at greater risk?
- Who else lives in/regularly visits the household? Can I provide their personal details and relationships to the child/children?
- Has the situation been discussed with the child's general practitioner and other relevant health professionals, e.g. adult mental health?
- Have I updated myself on the child and family's recent health history?
- Do I have knowledge of any siblings? May they be at risk of harm too?
- Is there a social worker already allocated? Have I discussed the referral with that social worker?
- Has the situation been discussed with a named nurse/senior colleague for safeguarding?

### Prior to making a call, have the following available:

- the child's health record
- a chronology of significant and recent events
- the evidence triggering your concern

## Section B:
## Aide-memoir to support efficient and appropriate telephone referrals of children who may be suffering, or are likely to suffer significant harm

| | |
|---|---|
| S | **Situation**<br>• This is the health visitor (give name) for (give your area). I am calling about...(child's/children's names, address and date of birth).<br>• To whom am I speaking? (Ensure you log the main role of the person taking the referral).<br>• I am calling because I believe this/these child/ren may be at risk of significant harm.<br>• The parents are/aren't aware of the referral. |
| A | **Assessment and Actions**<br>• I have assessed the child personally and the specific concerns are….. (provide specific factual evidence, ensuring the points in Section A are covered).<br>• Or: I fear for the child's safety because…(provide specific facts – what you have seen, heard and/or been told, and when you last saw the child and parents).<br>• A CAF has/hasn't been followed.<br>• This is a change since I last saw him/her (give number of) days/weeks/months ago.<br>• The child is now.....(describe current condition and whereabouts).<br>• I have not been able to assess the child/children but I am concerned because.....<br>• I have.....(actions taken to make child safe). |
| F | **Family factors**<br>• Specific family factors making this child at risk of significant harm are: .....(based on the Assessment of Need Framework and covering specific points in section A).<br>• Additional factors creating vulnerability are…..<br>• Although not enough to make this child/ren safe now, the strengths in the family situation are..... |
| E | **Expected response**<br>• In line with Working Together to Safeguard Children, NICE guidance and Section 17 and/or Section 47 of the Children Act I recommend that a specialist social care assessment is undertaken (urgently?).<br>• Other recommendations?<br>• Ask: Do you need me to do anything now? |
| R | **Referral and recording**<br>• I will follow up with a written referral and would appreciate it if you would get back to me as soon as you have decided your course of action. When might I expect to hear from you?<br>• Exchange names and contact details with person taking the referral.<br>• Now refer in writing as per local procedures (LSCB) and record details, time and outcomes of telephone referral.<br>• If the referral is not accepted /actioned, consult the escalation policy/process and discuss this with the named nurse. |

(NB: The intention is to make reasons for referral factual and informative to assist the duty team in taking appropriate action.)

If a child is at risk of immediate, significant harm, the priority is to move them to a place of safety. The police have the powers to remove a child to a place of safety without parental consent

*The Children's Act (1989) defined harm as 'ill treatment or the impairment of health or development'. To decide whether harm is significant the potential/current health and development of the child in question should be considered compared to that of a similar child


References

- Brandon et al (2012) New learning from serious case reviews a two year report for 2009-2011. Department for Education Research Report. DfE-RR226.
- HM Government (2013) Working Together to Safeguard Children. http://www.workingtogetehronline.co.uk/resources.html
- Your local safeguarding policy and procedures.
- Framework for the Assessment of Children in Need and their Families. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicatioinsPolicyAndGuidance/DH_4003256.
- NICE (2009) When to suspect child maltreatment. NICE Clinical Guideline 89.
- Children Act (1989) HMSO.
- DCSF.(2006) What to do if you are worried a child has been abused.
- Pocket information sharing guide (2008) HM Government.


The SAFER tool was developed from another SBAR which originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA


Amended and updated by the Institute of Health Visiting, 2013 on behalf of the Department of Health

## Appendix 4 - Resources

| Level 1 | Resources |
|---|---|
| Children should access universal services in a normal way:- | Key universal services that may provide support at this level:<br>Education<br>Children's Centres and Early Years<br>Health visiting service<br>School nursing<br>GP<br>Play Services<br>Police<br>Housing<br>Voluntary and Community Sector |
| **Level 2/3** | **Resources** |
| All universal services<br>Targeted Support Services<br>An Early help assessment is recommended at this level to<br>further assess needs and coordinate an action plan across<br>services<br>Statutory or specialist services assessment Education, Health and Care Plan<br>(EHCP) | Programmes aiming to build<br>self-esteem and enhance<br>social/life skills<br>Prevention Programmes<br>Positive activities<br>Youth crime prevention services.<br>Targeted drug and alcohol information, advice and education, including harm reduction advice to support informed choices<br>Health, Education, Children's Centres and Early Years<br>Educational psychology<br>Educational Welfare<br>Specialist Play Services<br>Voluntary and community services<br>Parenting Programmes |

| **Level 3 /4** | **Resources** |
|---|---|
| Targeted early help<br>All universal services plus key agencies:<br>Local authority children's social care | Other statutory service, e.g. SEN services.<br>Specialist health or disability services<br>Family and Young People Support Services<br>Youth Offending Service<br>Targeted drug and alcohol<br>Children and Adolescents Mental Health Service (CAMHS)<br>Voluntary and community |
| **Level 5** | **Resources** |
| All universal services plus additional services:<br>Social Care Single Assessment/ S47 enquiries<br>Statutory or specialist services assessment<br>Education, Health and Care Plan (EHCP) | Key agencies that may provide support at this level:<br>Specialist health or 0-25 Team<br>Children Social Care<br>Youth Offending Service<br>Children, Adolescent and Mental Health Services (CAMHS)<br>Family and Young People Support Services<br>Voluntary services |

## Appendix 5 - Glossary

| Abbreviation | Meaning |
|---|---|
| ACE | **Adverse Childhood Experiences** |
| ADHD | **Attention Deficit Hyperactivity Disorder** |
| ASD | **Autistic Spectrum Disorder** |
| B&NES | **Bath and North East Somerset** |
| CAF | **Common Assessment Framework now replaced with Early Help Assessment** |
| CAMHS | **Child and Adolescent Mental Health Services** |
| Care Leaver | **A care leaver is an adult who has spent time in foster or residential care, or in other arrangements outside their immediate or extended family before the age of 18.** |
| CCE | **Child Criminal Exploitation** |
| CCG | **Clinical Commissioning Group** |
| CIN | **Child in Need** |
| CSE | **Child Sexual Exploitation** |
| CP | **Child Protection** |
| C&YP | **Children and Young People** |
| Early Years | **The Early Years Foundation Stage (EYFS) sets standards for the learning, development and care of children from birth to 5 years old.** |
| ED | **Emergency Department** |
| EHCP | **Early Help Care Plan** |
| GDPR | **General Data Protection Regulations** |
| GP | **General Practitioner** |
| HV | **Health Visitor** |
| LADO | **Looked After Designated Officer** |
| Looked After Child | **A child who has been in the care of their local authority for more than 24 hours is known as a looked after child.** |
| MAPPA | **Multi-Agency Public Protection Arrangements** |
| MARAC | **Multi-Agency Risk Assessment Conference** |
| SEN | **Special Educational Needs** |
| SID / SUDI | **Sudden Infant Death / Sudden Unexplained Death of Infant** |
| SBAR | **Situation, Background, Assessment and Recommendation Communication Tool** |
| STI | **Sexually Transmitted Infections** |
| TAC / F | **Team Around Child/Family** |
| UTI | **Urinary Tract Infections** |
| WNB | **Was Not Brought** |
| WTTSC | **Working Together to Safeguard Children** |