Multi-agency Thresholds Document

Sandwell Children's Safeguarding Partnership

STRENGTHENING MULTI AGENCY AND COMMUNITY EFFORTS

TO SAFEGUARD CHILDREN AND YOUNG PEOPLE

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Contents

Foreword

Safeguarding children in Sandwell is everyone's responsibility.

"Our vision is for all children to be safe at home and in their communities, where they are loved, cared for and have the stability to grow healthily and to achieve their ambition".

This refreshed Multi Agency Thresholds Document produced by Sandwell Children Safeguarding Partnership (SCSP), provides a framework to help you identify when a child may need additional support to achieve their full potential through a graduated response from universal, early help, targeted early help or specialist services. It is produced in line with relevant statutory guidance and procedures; it should be noted that this framework is not intended to be fully prescriptive. It should be read in conjunction with relevant local and national guidance, west midlands safeguarding procedures and local partnership guidance's.

Working Together to Safeguard Children 2018 is a statutory guide to interagency working to safeguard and promote the welfare of children. It states: "In making their local arrangements, the safeguarding partners (SCSP), should agree with their relevant agencies the levels for the different types of assessment and services to be commissioned and delivered. This should include services for children who have suffered or are likely to suffer abuse and neglect whether from within the family or from external threats. This should also include services for disabled children and emphasises the importance of "early help".

The safeguarding partners should publish a threshold document, which sets out the local criteria for action in a way that is transparent, accessible and easily understood. This should include:

- the process for the early help assessment and the type and level of early help services to be provided
- the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under:
  - section 17 of the Children Act 1989 (children in need)
  - section 47 of the Children Act 1989 (reasonable cause to suspect a child is suffering or likely to suffer significant harm)
  - section 31 of the Children Act 1989 (care and supervision orders)
  - section 20 of the Children Act 1989 (duty to accommodate a child)
- clear procedures and processes for cases relating to:
  - the abuse, neglect and exploitation of children
  - children managed within the youth secure estate
  - disabled children."

Our thresholds offer relies upon a workforce where staff from across all agencies share the core values, knowledge, skills and abilities to engage well with children and families by building relationships which are based on the strengths within a family. Effective safeguarding systems are child centred, it is incumbent on agencies in Sandwell to work together to identify children with additional needs and provide support at the earliest opportunity. Children must be listened to and have their voices heard; you should ensure you focus on the needs and views of the child. There also need to be focus on solutions, the ability to motivate to achieve positive change and be aware of risk and protective factors. We know that by working effectively together we can identify vulnerable children early to ensure that we keep them safe, support their families and transform their lives.

This document is therefore relevant to Practitioners and Managers in all agencies and organisations providing services to children and families in Sandwell.

1. Introduction

What is the purpose of the guidance

1.1. The Sandwell Childrens Safeguarding Partnership have refreshed this guidance to ensure that the actions for support are clear, timely, consistently applied and inclusive to children and young people, and that there is a baseline understanding:

- ✓ that an early help assessment is, in all but urgent cases, is the starting point in meeting a child's needs;
- ✓ that what should follow from this is a plan of work on a multi-agency basis which improves a situation and outcomes for a child at the earliest possible stage;
- ✓ that any agency can be the role of the lead professional and we all have individual responsibilities when working with children, young people and families;
- ✓ that a common language is used;
- ✓ that all interventions are in line with regulation and good practice;
- ✓ about the responsibility of different agencies; and
- ✓ about the tools in place to support professionals in their role.

How has the guidance been developed?

1.2. The guidance has been written by a range of practitioners and managers who have been involved in design and delivery of this approach. It includes contribution from Sandwell's Voluntary and Community Sector, Sandwell Children's Trust, Sandwell Schools, Health Providers, Metropolitan Borough Council, Sandwell and West Birmingham Clinical Commissioning Group and West Midlands Police.

What does the guidance include?

1.3. The guidance describes the agreed overarching approach taken by Sandwell Safeguarding Partnership to support children, young people and their families (from pre-birth to 18 years of age).

1.4. This multiagency threshold document seeks to:

- Set out the principles that underpin the way Sandwell practitioners will work with children young people and families
- Describe levels of need and vulnerability and the appropriate response at different levels
- Make clear the thresholds for action / intervention

How should the guidance be used?

1.5. This document is only intended to offer guidance about the type of need which would trigger service, and therefore a reference tool for practitioners. There will be circumstances in which children's needs will cross tiers and for which practitioners will need to seek advice and guidance which are signposted in this document to those from your own organisation to ensure service provision is having an impact.

Expectations

1.6. It is the expectation of the Sandwell Children's Safeguarding Partnership that all practitioners working with children, young people and their families will operate within this guidance, as reinforced within the Regional Child Protection procedures for West Midlands.

1.7. All children, young people and their families have basic needs that are provided through universal services. These include education, early years, health, youth services, leisure facilities, and the many services provided by voluntary organisations. However; some children, young people and their families have additional needs requiring support by Targeted and Statutory Social Work Services.

1.8. All practitioners that have contact with children and their families, who identify additional needs, are deemed to be the 'Lead Professional' until such time where an Early Help Assessment (EHA) is coordinated or completed and it is clear that the child and family require intra or multiagency support and a team around the family (TAF) is established.

1.9. You will remain the Lead Professional until is agreed within the TAF that another a practitioner from the TAF is better placed to undertake this role.

1.10. All organisations and agencies should ensure that managers and staff have access to appropriate levels of support when working with children and families.

Where do I go for more advice and guidance?

1.11. The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all advice, guidance and consultation on applying threshold criteria to the circumstances of a child or family where you have identified additional needs or where your concerns are such that you have made the decision to make a referral.

1.12. The single point of contact is in the MASH and should be used by all agencies/organisations, including members of the public.

If a child is in imminent danger and at risk of significant harm the referrer should call the Police or ambulance service on 999.
All agencies and organisations thereafter should make a referral to Sandwell Children's Social Care by telephoning the **Single Point of Contact within the MASH on 0121 569 3100 (24 hour line).**
All agency / organisation referral will be expected to complete and submit a **MARF** without delay.

Role of the LADO

Allegations against staff or volunteers working with children and young people

1.13. Allegations are sometimes made against professionals or others working with children. It is a legal requirement that any agency must inform the designated officer (known as the LADO) within one working day when an allegation is made against any member of staff or volunteer and prior to any further investigation taking place.

1.14. The MASH will receive all referrals to the Local Authority Designated Officer (LADO), where referrals involve an alleged perpetrator of abuse who either works or volunteers with children.

1.15. All referrals should be made through the SPOC at the MASH on the SCSP multi-agency referral form (MARF). For further guidance please refer to the management of Allegations Against Staff or Volunteers aka Position of Trust process on the SCSP website here.

2. Principles and definitions

2.1. Appendix 2 of this document - the Thresholds Matrix - provides illustrative examples about how need might present itself, rather than an exhaustive list of fixed criteria that must be met. The level of need will be increased where there is a multiplicity of factors and the practitioner's professional judgement will always be required.

2.2. The following principles should be considered in applying the framework:

- A child is anyone who has not reached their 18th birthday including unborn children (Children Act 1989)
- All children have the right to grow up safe from harm and to reach their potential.
- Children are best supported and protected when additional needs are identified early, and the support is provided in a timely manner and commensurate to these needs.
- The Children Act (1989/2004/2017) encourages agencies where ever possible, to work in partnership with families and to make onward referrals with their consent. If the practitioner believes that the child may be at risk of significant harm and that consent may place the child at further risk they should take advice from their Safeguarding Lead and clearly state at the point of referral, why consent has not been sought.
- Support should be delivered at the lowest appropriate level to meet the child's needs thus preventing the need for escalation to more specialist services.
- Support should be based on assessment and intervention delivered through a clear plan of work which is regularly reviewed. This may include the completion of an Early Help Assessment (EHA) and the creation of a Team Around the Family (TAF).
- Work must be child focussed and care taken to ensure that children/parents/ carers/agencies understand the plan, how this will be delivered and their role in implementing the plan.
- Children with disabilities may have additional needs related to their communication / mobility and depend on others for their basic care needs to be met, which can increase their vulnerability.

2.3. The term Lead Professional is used within the Framework to mean someone who takes the lead to co-ordinate provision and be a single point of contact for a child and their family. When a range of services are involved with the child or family, an integrated response is required.

2.4. Targeted Support is an approach to working with children and families who are below the threshold of social care intervention but require a multi-agency approach that stops problems escalating and supports families to improve their situation.

2.5. Signs of Safety (SofS) is the chosen multiagency approach of intervention with children, young people and their families. It is designed to integrate professional and family knowledge in the assessment of risk and any subsequent planning.

2.6. When you have concerns about child neglect, please use the Graded Care Profile 2, which includes a profile tool to assess children, as part of your MASH referral.

3. Levels of intervention and need

3.1. Working Together to Safeguard Children (Department for Education 2018) makes it clear that safeguarding children and promoting their welfare is the responsibility of all practitioners/ working with children and that they should understand the criteria for taking action across a continuum of need if required.

3.2. This will include protecting children from maltreatment; ensuring that children grow up in circumstances consistent with safe and effective care; taking action to prevent impairment of children's health and development and taking action to ensure children achieve the best outcomes. The voice of the child and their wishes and feelings must be ascertained and recorded where possible and due consideration given to them, having regard to his/her age and understanding.

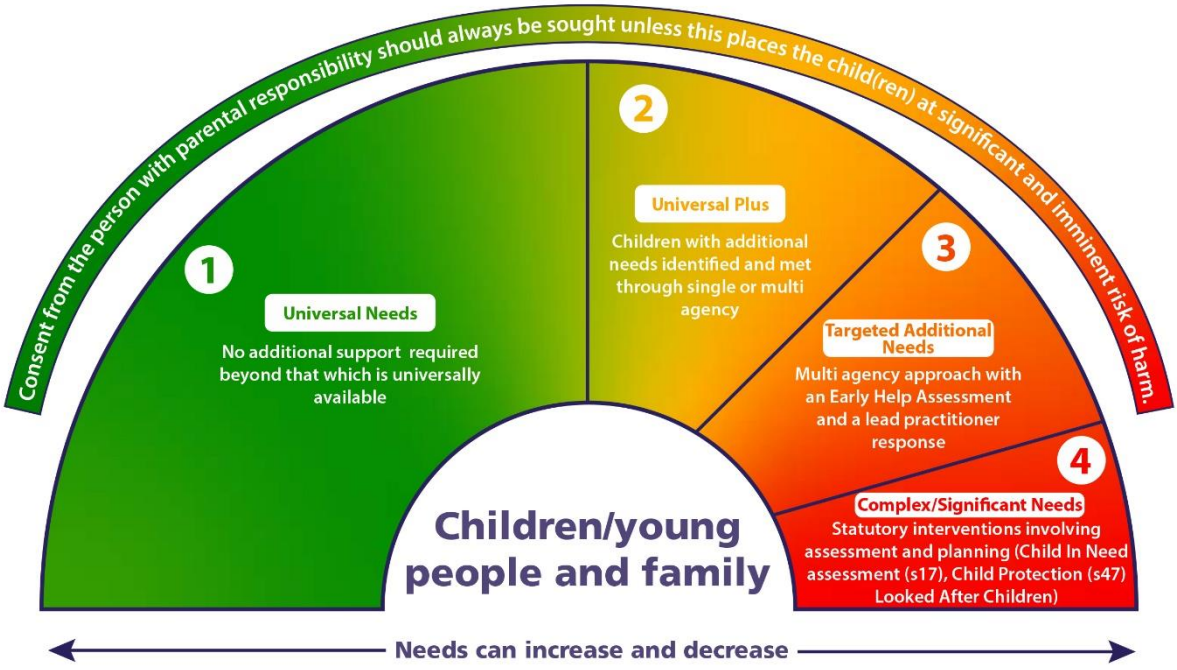
3.3. This Threshold Document sets out **four levels of need** and provides guidance to individuals, agencies and staff to help them to identify a child's level of need and determine whether additional services are required. It is not a rigid set of procedures; every child is unique, and their needs will change over time. practitioners should seek advice from the safeguarding lead from within their own organisations. If required, they can seek guidance through the Single Point of Contact (SPOC) within the Multi - agency Safeguarding Hub (MASH) on 0121 5693100 (line open 24 hours).

3.4. Children and families are supported most effectively and efficiently when services and information sharing are planned and delivered in a co-ordinated way.

3.5. By working together agencies can significantly improve outcomes for children and families. Evidence shows that a multi-agency approach is needed to identify vulnerable families early and effectively. Many of the risk factors that are typically seen as the business of one agency can also be supported by other service providers.

3.6. Sandwell Children's Safeguarding Partnership has adopted a common approach to describing the levels of need and the support that may be required by children, young

people and their families. This is commonly known as the *'continuum of need and support'* illustrated below.



3.7. The four levels of intervention - **Universal; Universal Plus; Targeted Additional Needs; Complex/Significant Needs** – as illustrated in the windscreen model above provides the *'indicators of needs and risks'* to help describe the circumstances in which an **Early Help Assessment (EHA)** should be considered and when a referral to Children's Social Care may be necessary alongside a range of universal services.

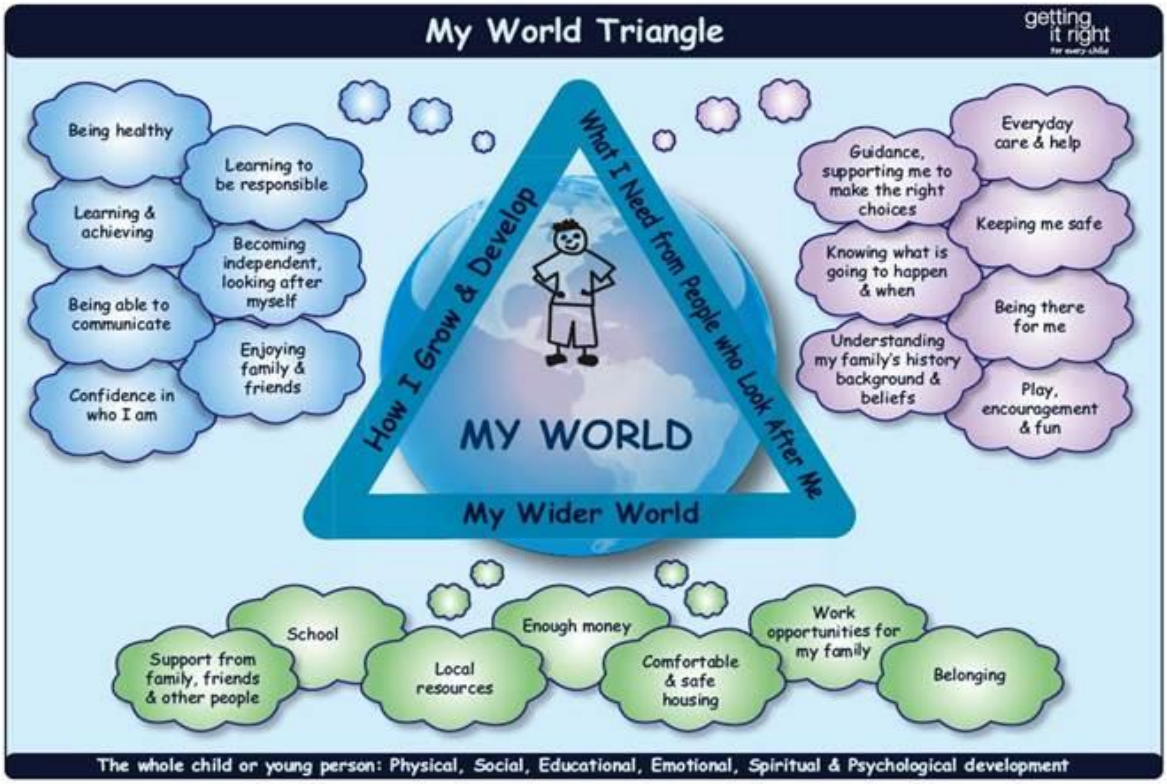
3.8. An 'Early Help Assessment' is completed when there is an emerging need **(from universal plus to targeted additional needs)** or when needs decrease and the work can step down.

3.9. The indicators of need for each level of intervention are split into three domains in line with the *'Framework for the Assessment of Children in Need and their Families'*.

The Framework for the Assessment of Children in Need and their Families and My World

3.10. The Framework for the Assessment of Children in Need and their Families (assessment triangle) is a visual tool to assist in the assessment of three domains - **Child's Developmental Needs; Parenting Capacity; Family & Environmental Factors**.

3.11. Below is the description of the domains from a child perspective. The My World Triangle is adapted from Glasgow's 2005 guidance on the Integrated Assessment Framework.



3.12. Each of these domains are represented by a side of the assessment triangle and correspond to the three domains used in the Threshold Matrix. Assessments should take account of all three domains and how these impact on the child and their development.

3.13. In summary the **Thresholds Matrix** is a framework that has combined the *'continuum of need' and the 'assessment triangle'* to provide practitioners with a systematic basis for collecting and analysing information to support professional judgements by practitioners about how to help children and families in the best interests of the child.

How to use the Matrix

3.14. Practitioners should use the Threshold Matrix to gain an understanding of a child's developmental needs; the capacity of parents or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm; and the impact of wider family and environmental factors on the parents and child. The complex interplay of factors across all three domains should be carefully understood and analysed.

3.15. Practitioners are therefore encouraged to use their knowledge and skills to be involved in:

- ✓ information gathering;
- ✓ professional judgement;
- ✓ analysis; and
- ✓ consideration of risk.

3.16. The Early Help Assessment in its entirety can be used to enable practitioners to identify strategies and interventions to support families whose needs fall below the social care threshold.

3.17. If, however, the level of need is judged to be greater than targeted additional needs, and is complex significant needs, then you should follow the SCSP multiagency child protection procedures immediately.

Which level of need?

3.18. The list of indicators contained in this document is not exhaustive and is guidance. In assessing need and risk that require specialist services, multiple factors are likely to be present and decisions as to whether the criteria are met remain a professional judgement by practitioners and their line managers. It is also important to remember that the signs that a child or young person has particular needs are often not found in a single piece of evidence but in a combination of factors or indicators.

3.19. The model is intended to ensure the early identification of children and families who require additional help. It aims to prevent children moving towards higher levels of need and to reduce the level of need wherever possible.

3.20. Children may present with needs at different levels. Inter-disciplinary discussion and co-ordination will ensure appropriate services are arranged.

3.21. It is acknowledged that children may move up and down from one level to another and that agencies (including universal services) will offer support at more than one level. Although the practitioner may refer a family for a more targeted service, it is expected that the practitioner will still engage with the family during assessment and is likely to continue to have a role in TAF meetings.

3.22. Support is available with the decision-making process. All agencies will have a safeguarding lead that will usually be part of the threshold discussion. Practitioners

should not delay referral of urgent matters due to the unavailability of their safeguarding lead.

Consent and Information sharing

3.23. Children and families have a right to expect their personal information will be handled confidentially and you should always seek their consent and co-operation if you want to share information about them. If a child or family refuses to give consent to share their information their wishes should be respected except where a child's/individual's/people's safety may be at risk or when it is not appropriate to seek the child or family member's agreement to share their information. If you share personal information without an individual's consent it is within your judgement to make the decision based on the fact that the lack of consent is overridden in the public interest. You must record the reasons for your decision. In cases where you are not certain about whether to share information with other agencies, check with your designated safeguarding leads.

3.24. Information sharing is essential to enable early intervention and preventative work for safeguarding and promoting welfare and for wider public protection. A key factor identified in many serious case reviews (SCRs) has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action.

3.25. For the seven golden rules for information sharing, *(Information Sharing: Advice for practitioners providing safeguarding services (March 2015, Department for Education: Updated 4 July 2018) and Sandwell's Information Sharing Protocol, Guidance on Making a Referral, Information Sharing and Seeking Parental Consent which can be found on the SCSP website.*

3.26. Where children have an identified lead professional or allocated social worker; any concerns should be discussed with them (or their manager) in the first instance. A Multi-Agency Referral Form (MARF) would not be required.

3.27. Following guidance from the designated safeguarding lead within their agency, if a child protection concern is identified, the referrer is required to complete a MARF and submit it to the MASH within 1 hour of alert of the concern.

Resolving Practitioner Disagreements and Escalation of Concerns

3.28. The SCSP Resolution and Escalation Policy contain details on the resolution processes appropriate in circumstances where differences exist between the agencies regarding the handling of a case.

Whistleblowing

3.29 Whistleblowing or confidential reporting polices are designed to encourage any member of staff to raise concerns if they suspect malpractice in their organisation. The Public Interest Disclosure Act 1998 encourages individuals to raise concerns about malpractice in the workplace. Staff should raise concerns within their organisation first unless they think the employer will cover it up, would treat them unfairly if they complained or hasn't sorted it out and they've already told them. If a member of staff believes that a reported allegation or concern is not being dealt with appropriately by their organisation, they should report the matter to the Designated Officer (LADO)

For further information, see *Raising concerns at work: whistle-blowing guidance for workers and employers in health and social care*.

4. Accessing support for children and families

4.1. Once the practitioner has used the Threshold matrix (Appendix 2) they should determine what the best course of action will be:

- Continue provision through universal services (level 1).
- Record and monitor using agency internal recording system/processes (level 2).
- Complete an Early Help Assessment (level 2 & 3)
- Refer to children's social care by completing a MARF (level 4).

4.2. **Levels 1** is expected levels of support services to families. In these circumstances partner agencies are expected to intervene and provide support to a child and family in order to prevent deterioration in care and needs of children and escalating levels of support from specialist services.

4.3. **Level 2** indicates an increase in need and support provision. It is at this point where all practitioners need to start an Early Help Assessment. The responsibilities of the Lead Professional should be undertaken by the practitioner who has identified the originating concerns for the child and family until the point where a team around the family (TAF) meeting is convened and a decision is made with the family who is best placed to undertake the Lead Professional role. In these circumstances practitioners will need to obtain consent from families to commence an EHA, gather and share information with other agencies. Practitioners need to give consideration to whether

the child and family needs can be met by single agency or a number of services within that agency or whether additional agency support is required reduce need.

4.4. **Levels 3 and 4** identify the point at which Sandwell Childrens Trust Children's Social Care will become involved with children and families. Practitioners will have identified that the child(ren) have additional or complex needs, including whether a child(ren) is at risk of harm without statutory intervention or have identified that the child is suffering harm. In these circumstances a referral must always be made to the MASH where a decision will be made as to whether a single assessment should be undertaken. The purpose of the single assessment is to gather information and to analyse the needs of the child or children and/or their family and the nature and level of any risk of harm to the child(ren).

At all levels (1-4) of child and family need, consent from the person with parental responsibility should always be sought unless this places the child(ren) at significant and imminent risk of harm.

4.5. If a practitioner is unclear about whether to complete an Early Help Assessment (EHA) or MARF they should in the first instance consult the designated Safeguarding Lead within their agency. If the designated lead is not available, then advice from a qualified social worker can be obtained through the:

Multi-agency Safeguarding Hub (MASH) 24 hour line - 0121 569 3100

4.6. ## From Practitioner to the role of Lead Professional

4.7. All practitioners that have contact with children and their families, who identify the universal, additional and targeted need, are required to undertake the responsibilities of the Lead professional /or are deemed to be the 'Lead Professional' until such time where an early help assessment (EHA) is coordinated or completed and it is clear that the child and family require coordination of services from a single agency or multiagency support services and a team around the family (TAF) is established.

4.8. When an EHA identifies that multi-agency, support is required to meet the needs of the child and family then this team becomes the TAF and is responsible for developing and implementing the support plan for the child and family.

4.9. Practitioners will retain the responsibilities / or remain the Lead Professional until the first meeting of the TAF where alongside the parent/carer the TAF will agree who is best placed to become the Lead Professional - **this may not always be the**

practitioner who has identified the originating needs of the child and family or completed the Early Help Assessment.

4.10. The identified Lead Professional will co-ordinate the agreed TAF plan and ensure that regular TAF meetings are held.

4.11. **Urgent advice** - Where children are not known to Children's Social Care and urgent advice is needed by the agencies safeguarding lead, the Single Point of Contact (SPOC) at the multiagency Safeguarding Hub (MASH) can be contacted by telephoning 0121 569 3100.

4.12. All children receiving a service from Children's Social Care will have a plan in place, which will be a ***Child Protection Plan, Child in Need Plan, Children Looked After (CLA) Care Plan or a Pathway Plan.*** In these circumstances the child and family will not require a TAF plan.

Appendix 1: Key contact details

Early Help Assessment

Further information on how to complete the Early Help Assessment is available at www.sandwell.gov.uk/families

Targeted Early Help Teams(COGs):

The teams can be accessed in office hours on the numbers below

Team	Address	Email	Telephone
Oldbury	Oldbury Council House, Freeth Street, Oldbury, B69 3DE	oldbury_cog@sandwell.gov.uk	0121 569 7295
Rowley	Payne Street, Blackheath, B65 0DH	rowley_cog@sandwell.gov.uk	0121 569 7296
Smethwick	Town Hall, High Street, Smethwick, B66 3NT	smethwick_cog@sandwell.gov.uk	0121 569 7297
Tipton	High Street, Tipton, DY4 9JB (located in Tipton Local)	tipton_cog@sandwell.gov.uk	0121 569 7291
Wednesbury	Wednesbury Town Hall, Holyhead Road, Wednesbury, WS10 7DF	wednesbury_cog@sandwell.gov.uk	0121 569 7294
West Bromwich	Court House, High Street, West Bromwich, B70 8LU	westbromwich_cog@sandwell.gov.uk	0121 569 7293

Child Protection Referral: Emergency

If a child is in imminent danger and at risk of significant harm and therefore reporting concerns cannot wait an hour while a MARF is completed, a practitioner should call 999 in the first instance for Police or an Ambulance and contacting Children's Social Care by telephoning the Single Point of Contact within the MASH on **0121 569 3100 (24 Hour Line)**. They will also be expected to complete a MARF without delay.

Child Protection Referral: Non-Emergency
If there is no immediate danger but the child has met the threshold for involvement from Children's Social Care, the practitioner should complete and submit a MARF within 1 hour. They will not be required to telephone Children's Social Care to inform them of the referral (unless a disclosure has been made and the child is due to leave the service/ provision) but it is vital that the referrer is available to discuss the referral. The MARF and guidance on completing a MARF can be found at **https://www.sandwellcsp.org.uk** MARFs should be sent by secure email to **access_team@sandwellchildrenstrust.org** with the subject title MARF. For those agencies that do not have secure email, password protect the MARF before sending and forward a further email with the password details.

Appendix 2: Threshold Matrix

Parent or Carer's Capacity			
Universal	**Universal Plus**	**Targeted Additional Needs**	**Complex/ Significant Needs**
Children with no additional needs and where there are no concerns. Typically, these children are likely to live in a resilient and protective environment where their needs are met. These children will require no additional support beyond that which is universally available. These indicators need to be kept in mind when assessing the significance of indicators from Universal Plus; Targeted Additional Needs; Complex/Significant Needs.	These children can be defined as needing some additional support without which they would be at risk of not meeting their full potential. Their identified needs may relate to their health, educational, or social development, and are likely to be short term needs. If ignored these issues may develop into more worrying concerns for the child or young person. These children will be living in greater adversity than most other children or have a greater degree of vulnerability than most if their needs are not clear, not known or not being met and multi-agency intervention is required, a **lead professional** may be identified to coordinate a support plan around the child.	This Level applies to those children identified as requiring specialist support. It is likely that for these children their needs and care are compromised. Only a small fraction of children will fall within this band. These children will be those who vulnerable or experiencing the greatest level of adversity. **Children with additional needs:** These children may be eligible for services from the local Targeted Early Help Team (COG) / Children's Social Care and are potentially at risk of developing acute/ complex needs if they do not receive early statutory intervention. If a social worker is allocated they will usually act as the lead Practitioners and coordinate services.	These are children whose needs and care at the present time are likely to be significantly compromised thereby requiring assessment under Section 47 (may be suffering or likely to suffer significant harm) or Section 17 (Child in Need) of the Children Act 1989. These children may become subject to a child protection plan and need to be accommodated (taken into care) by Children's Social Care either on a voluntary basis or by way of Court Order. Section 17-1989 Children Act states a child shall be taken to be in need if: (a) He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part; (b) His health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) He is disabled .
Parent or Carers Capacity	**Parent or Carers Capacity**	**Parent or Carers Capacity**	**Parent or Carers Capacity**
Basic Care, Safety and Protection • Parents/carers provide for child's physical needs: food, drink, appropriate clothing, medical and dental care. • Parents/carers protect from danger or significant harm, in the home and elsewhere.	**Basic Care, Safety and Protection** • Requiring support to provide consistent care e.g. safe and appropriate childcare arrangements; safe and hygienic home conditions; adequate diet. • The following parental factors impact on the health or development of the child unless appropriate support provided: health; mental health; learning difficulties; disability; and substance misuse. • Poor engagement with universal services likely to impact on child's health or development. • Parents/carers have had additional support to care for previous child/young person.	**Basic Care, Safety and Protection** • Parent/Carer is able to meet child's needs with support but is not providing adequate care. • Concern that an unborn child (of at least 16 weeks' gestation) may be risk of harm. • The following parental factors have a direct impact on child's health or development: mental health difficulties; substance misuse; and learning difficulties. • Child has indirect contact with individuals who pose a risk of physical or sexual harm to children. • History of previous child protection concerns. • Practitioners have escalating concerns.	**Basic Care, Safety and Protection** • Parents/carers are unable to care for the child. • Parents/carers have or may have abused/neglected the child/young person. • Pre-birth assessment indicates unborn child is at risk of significant harm. • Chronic or acute neglect where food, warmth and other basics often not available.

	• Parent requires advice on parenting issues. • Practitioners are beginning to have some concerns around child's physical needs being met. • Some exposure to dangerous situations in home/community where risk is accepted by parent and managed.	• Child experiencing unsafe situations. • Elements of neglect are present where food, warmth and other basics not available that with support would improve.	• Parents' own needs mean they cannot keep child/young person safe. • Parent unable/ unwilling to restrict access to home by adults known to be a risk to children and other adults. • Child/young person left in the care of an adult known or suspected to be a risk to children or lives in the same house as the child. • Low warmth, high criticism is an enduring feature of the parenting style. • Parent's own emotional needs/experiences persistently impact on their ability to meet the child/young person's needs. • The following parental factors present a risk of significant harm to the child: mental health
Parent or Carers Capacity	**Parent or Carers Capacity**	**Parent or Carers Capacity**	**Parent or Carers Capacity**
			• issues; substance misuse; learning difficulties; health/disability. • Previous child/young person(s) have been removed from parent's care. • There is an instability and violence in the home continually. • Suspicion of Trafficking • Suspicion of Modern Slavery
Emotional Warmth and Stability • Parents/carers show warm regard, praise and encouragement. • Parents/carers ensure that secure attachments are not disrupted. • Parents/carers provide consistency of emotional warmth over time.	**Emotional Warmth and Stability** • Difficulties with attachment. • Inconsistent responses to child by parents e.g. discipline and praise. • Lack of response to concerns raised about child's welfare. • Able to develop positive relationships with others (not the child). • Lack of stability and multiple changes of home address and school	**Emotional Warmth and Stability** • Parent is emotionally unavailable. • Succession/multiple carers or multiple carers, but no significant relationships with any of them or others. • Inappropriate child care arrangements. • Receives erratic/inconsistent care/parenting. • Parental instability affects capacity to nurture.	**Emotional Warmth and Stability** • Deliberate cruelty or emotional ill treatment of a child resulting in significant harm. • Child is continually the subject of negative comments and criticism or is used as a scapegoat by a parent/carer, resulting in feelings of low worth and self-esteem and seriously impacting on the child's emotional and psychological development. • Beyond parental-control. • Has no-one to care for him/her.

Guidance Boundaries and Stimulation • Parents/carers provide guidance so that child can develop an appropriate internal model of values and conscience. • Parents/carers facilitate cognitive development through interaction and play. • Parents/carers enable child to experience success.	**Guidance Boundaries and Stimulation** • Inconsistent parenting in respect to routine and boundary setting for child's stage of development and maturity. • Parent has age inappropriate expectations that child or young person should be self-reliant. • Lack of response to concerns raised about child. • Child not exposed to new experiences and spends much time alone. • Can behave in an anti-social way.	**Guidance, Boundaries and Stimulation** • Child/young person receives little positive stimulation – lack of new experiences or activities. • Parents/carers provide inconsistent boundaries or present a negative role model. • Erratic/inadequate guidance provided.	**Guidance Boundaries and Stimulation** • Lack of appropriate supervision resulting in significant harm to child. • Child is given responsibilities that are inappropriate for their age/level of maturity resulting in significant harm to the child. • No constructive leisure time or guided play. • No effective boundaries set by parents (who) regularly behave in an anti-social way.

Family and Environmental Factors			
Universal	**Universal Plus**	**Targeted Additional Needs**	**Complex/ Significant Needs**
Children with no additional needs and where there are no concerns. Typically, these children are likely to live in a resilient and protective environment where their needs are met. These children will require no additional support beyond that which is universally available. These indicators need to be kept in mind when assessing the significance of indicators from Universal Plus; Targeted Additional Needs; Complex/Significant Needs.	These children can be defined as needing some additional support without which they would be at risk of not meeting their full potential. Their identified needs may relate to their health, educational, or social development, and are likely to be short term needs. If ignored these issues may develop into more worrying concerns for the child or young person. These children will be living in greater adversity than most other children or have a greater degree of vulnerability than most if their needs are not clear, not known or not being met and multi-agency intervention is required, a **lead professional** may be identified to coordinate a plan around the child.	This Level applies to those children identified as requiring specialist support. It is likely that for these children their needs and care are compromised. Only a small fraction of children will fall within this band. These children will be those who vulnerable or experiencing the greatest level of adversity. **Children with additional needs:** These children may be eligible for services from the local Targeted Early Help Team (COG)/ Children's Social Care and are potentially at risk of developing acute/ complex needs if they do not receive early statutory intervention. If a social worker is allocated they will usually act as the lead Practitioners and coordinate services.	These are children whose needs and care at the present time are likely to be significantly compromised thereby requiring assessment under Section 47 (may be suffering or likely to suffer significant harm) or Section 17 (Child in Need) of the Children Act 1989. These children may become subject to a child protection plan and need to be accommodated (taken into care) by Children's Social Care either on a voluntary basis or by way of Court Order. Section 17-1989 Children Act states a child shall be taken to be in need if: (a) He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part; (b) His health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) He is disabled.
Family & Environmental Factors	**Family & Environmental Factors**	**Family & Environmental Factors**	**Family & Environmental Factors**
Family & Social Relationships and Family Well-Being • Good relationships within family, including when parents are separated. • Few significant changes in family composition. • Sense of larger family network and good friendships outside of the family unit.	**Family & Social Relationships and Family Well-Being** • Parents/Carers have relationship difficulties which may affect the child. • Low level concerns about domestic abuse. • Parents/Carers request advice to manage their child's behaviour. • Child is a teenage parent. • Child is a young carer (may look after younger siblings). • Parent was a Looked After Child (LAC). • Large family with multiple young children. • Experienced loss of significant adult. • Some support from family/ friends.	**Family & Social Relationships and Family Well-Being** • Domestic abuse where the risk to the victim is assessed as standard/medium risk and the child is present within the home during the incident. • An initial domestic abuse incident is reported but the victim discloses details of historic abuse with children resident/normally resident. • Pre-birth assessment where a history of past child protection concerns. • Risk of family relationship breakdown leading to child becoming looked after outside of family network. • Child is a young carer requiring assessment of additional needs.	**Family & Social Relationships and Family Well-Being** • Assessment identifies risk of physical, emotional, sexual abuse or neglect. • History of previous significant harm to children, including any concerns of previous child deaths. • Family characterised by conflict and serious, chronic relationship difficulties. • Child is privately fostered. • Unaccompanied asylum-seeking children.

		• Child requires assessment for respite care service due to family circumstances and has no appropriate friend/relative/carer available to support. • Parents/carers are unable or unwilling to continue to care for the child. • Parent was a LAC child. • Acrimonious divorce/separation • Family has poor relationship with extended family/little communication.	• Parent/carer has unresolved mental health difficulties which affect the wellbeing of the child. • Adult victim of Domestic Abuse is assessed as high-level risk and the child (including unborn) is at risk of significant harm. • Child or young person is at risk of or exposed to Honour Based Violence (HBV) • Child or young person is at risk of Forced Marriage (FM) • Child's carer referred to MARAC. • Members of the wider family are known to be, or suspected of being, a risk to children. • Child needs to be looked after outside of their immediate family or parents/carers due to abuse/neglect.
Family & Environmental Factors	**Family & Environmental Factors**	**Family & Environmental Factors**	**Family & Environmental Factors**
		• Family is socially isolated.	• Significant parental discord and persistent domestic violence. • Destructive/unhelpful involvement from extended family
Housing, Employment and Finance • Housing has basic amenities and appropriate facilities. • Parents able to manage the working or unemployment arrangements and do not perceive them as unduly stressful. • Reasonable income over time, with resources used appropriately to meet individual needs.	**Housing, Employment and Finance** • Overcrowding (as per local housing guidelines) that has a potential impact on child's health or development • Families affected by low income/living with poverty affecting access to appropriate services to meet child's additional needs. • Wage earner has periods of no work/low income plus adverse additional factors which affect the child's development. • Parents have limited formal education which is affecting ability to find employment. • Family seeking asylum or refugees.	**Housing, Employment and Finance** • Extreme financial difficulties impacting on ability to have basic needs met. • Family at risk of eviction having already received support from Housing services. • Housing is in poor state of repair, temporary or overcrowded. • Parents stressed due to "overworking" or unemployment/parents may find it difficult to obtain employment due to poor basic skills.	**Housing, Employment and Finance** • Homeless child in need of accommodation including 16-17 year olds. • Hygiene conditions within the home present a serious and immediate environmental/health risk to children. • Physical accommodation places child in danger. • Family unable to gain employment due to lack of basic skills or long-term difficulties e.g. substance misuse. • Extreme poverty/debt impacting on ability to care for Child. • No financial support and no recourse to public funds (NRPF)

Social and Community Resources • Family feels integrated into the community and have good social and friendship networks exist. • Access to regular and positive activities within universal services.	**Social and Community Resources** • Family require advice regarding social exclusion e.g. hate crimes, harassment, and disputes in the community. • Family/child demonstrating low level anti-social behaviour towards others. • Limited access to contraceptive and sexual health advice, information and services. • Parents/carers are socially excluded, have no access to local facilities and require support services. • Family may be new to the area. • Adequate universal resources but family may have access issues.	**Social and Community Resources** • Significant levels of targeted hostility towards the child and their family, and conflict/volatility within neighbourhood. • Parents socially excluded and have lack of a support network. • Poor quality universal resources and access problems to these and targeted services.	**Social and Community Resources** • Child or family need immediate support and protection due to harassment/discrimination and have no local support. • Chronic social exclusion/no supportive network. • Poor quality services long-term access problems.

Child or Young Person's Developmental Needs			
Universal	**Universal Plus**	**Targeted Additional Needs**	**Complex/ Significant Needs**
Children with no additional needs and where there are no concerns. Typically, these children are likely to live in a resilient and protective environment where their needs are met. These children will require no additional support beyond that which is universally available. These indicators need to be kept in mind when assessing the significance of indicators from Universal Plus; Targeted Additional Needs; Complex/Significant Needs.	These children can be defined as needing some additional support without which they would be at risk of not meeting their full potential. Their identified needs may relate to their health, educational, or social development, and are likely to be short term needs. If ignored these issues may develop into more worrying concerns for the child or young person. These children will be living in greater adversity than most other children or have a greater degree of vulnerability than most if their needs are not clear, not known or not being met and multi-agency intervention is required, a **lead professional** may be identified to coordinate a plan around the child.	This Level applies to those children identified as requiring specialist support. It is likely that for these children their needs and care are compromised. Only a small fraction of children will fall within this band. These children will be those who vulnerable or experiencing the greatest level of adversity. **Children with additional needs:** These children may be eligible for services from the local Targeted Early Help Team (COG) / Children's Social Care and are potentially at risk of developing acute/ complex needs if they do not receive early statutory intervention. If a social worker is allocated they will usually act as the lead practitioners and coordinate services.	These are children whose needs and care at the present time are likely to be significantly compromised thereby requiring assessment under Section 47 (may be suffering or likely to suffer significant harm) or Section 17 (Child in Need) of the Children Act 1989. These children may become subject to a child protection plan and need to be accommodated (taken into care) by Children's Social Care either on a voluntary basis or by way of Court Order. Section 17-1989 Children Act states a child shall be taken to be in need if: (a) He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part; (b) His health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) He is disabled.
Child or Young Person's Developmental Needs	**Child or Young Person's Developmental Needs**	**Child or Young Person's Developmental Needs**	**Child or Young Person's Developmental Needs**
Learning/Education • Acquired a range of skills/interests. • Experiences of success/achievement. • No concerns around cognitive development. • Access to books/toys, play. • Good attendance at school (90% or more)/college/training.	**Learning/Education** • Occasional truanting, punctuality issues, attendance below 90%. • Not always engaged in learning, e.g. poor concentration, low motivation and interest. • The child's current rate of progress is inadequate despite receiving appropriate support and are not thought to be reaching educational potential. • Have some identified learning needs that place him/her on SEN Support Register • Lack of adequate parent/carer support for child's learning e.g. appropriate stimulation (books/toys) and opportunities to learn.	**Learning/Education** • Child not in education, in conjunction with concerns for child's safety. • Chronic non-attendance truanting / authorised absences/fixed term exclusions/punctuality issues. • Identified learning needs and may have an Education and Health Care Plan • Not achieving key stage benchmarks. • No interests/skills displayed.	**Learning/Education** • Child not in education, in conjunction with child protection concerns for child's safety. • Parent not actively engaging in the identification of a suitable provision

	• Child/young person under undue parental pressure to achieve/aspire or parent/carer lacks aspirations for child/young person. • Few or no qualifications leading to NEET (not in education, employment or training). • Not educated at school (or at home by Parents/Carers).		
Child or Young Person's Developmental Needs	**Child or Young Person's Developmental Needs**	**Child or Young Person's Developmental Needs**	**Child or Young Person's Developmental Needs**
Health • Physically well/healthy, developmental checks/immunisations are up to date and health appointments are kept. • Good state of mental health. • Developmental milestones appropriate and appropriate height and weight/growth. • Speech and language development met. • Adequate hygiene/clothing and nutritious diet. • Regular dental and optical care. • Sexual activity appropriate for age.	**Health** • Slow in reaching developmental milestones. • Child not being taken to appropriate routine medical appointments e.g. immunisations and developmental checks. • Missing set appointments across health including antenatal, hospital and GP appointments. • Is susceptible to minor health problems. • Minor concerns re growth and weight (above or below what would be expected). • Low level mental health or emotional issues. • Evidence of risk taking behaviour • i.e. drug/alcohol use, unprotected sex. • Minor concerns re diet/hygiene/clothing.	**Health** • Chronic/recurring health problems with missed appointments, routine and non-routine. • Delay in achieving physical and other developmental milestones, raising concerns. • Frequent accidental injuries to child requiring hospital treatment. • Some concerns around mental health, including self-harm and suicidal thoughts. • Poor or restricted diet despite intervention/dental decay/poor hygiene. • Child has chronic health problems or high-level disability which with extra support may/may not be maintained in a mainstream setting. • Learning significantly affected by health problems. • Overweight/underweight/enuresis/faltering growth.	**Health** • Parents/carers refusal to recognise or address high level disability, serious physical and/or emotional health. • Child not being taken to appropriate medical appointments which puts them at direct risk of significant harm. • Child with a disability in need of assessment and support to access appropriate specialist services. • Concerns that a child is suffering or likely to suffer harm because of fabricated or induced illness. • Child who is suspected to having suffered non-accidental, or serious unexplained, injuries. • Persistent substance misuse. • Developmental milestones unlikely to be met. • Early teenage pregnancy. • Serious mental health issues. • Dental decay and no access to treatment. • Sexual exploitation/abuse. • Non-organic faltering growth/failure of parent or carer to respond to faltering growth. • Female Genital Mutilation (known or suspected), including any suspicion that a young girl is being taken abroad for this purpose.
Social, Emotional, Behavioural, Identity • Demonstrates age appropriate responses in feelings and actions.	**Social, Emotional, Behavioural, Identity** • Emerging anti-social behaviour and attitudes and/or low-level offending.	**Social, Emotional, Behavioural, Identity** • Child with serious level of unexplained and inappropriate sexualised behaviour.	**Social, Emotional, Behavioural, Identity** • Challenging behaviour resulting in serious risk to the child and others.

• Good quality early attachments, child is appropriately comfortable in social situations. • Able to adapt to change and demonstrate empathy and express needs. • Demonstrates feelings of belonging and acceptance. • Positive sense of self and abilities. • Knowledgeable about the effects of crime and antisocial behaviour (age appropriate).	• Child is victim of bullying or bullies' others. • Expressing wish to become pregnant at young age. • Low level substance misuse (current or historical). • Low self-esteem. • Limited peer relationships/social isolation. • Expressing thoughts of running away. • Disruptive/challenging behaviour at school/neighbourhood/household. • Behavioural difficulties requiring further investigation/diagnosis. • Some difficulties with peer group relationships and with some adults. • Can find managing change difficult	• Child is at risk of sexual exploitation (refer to Appendix 3 for potential indicators). Parents are engaged and supportive. • Child currently/frequently missing from home and concerns raised about their physical and emotional safety and welfare. Parents engaged and supportive. • Child whose behaviour is putting them at risk, including substance and alcohol misuse. • Evidence of regular/frequent substance misuse which may combine with other risk factors. • Continuous breeches of curfew order with other risk-taking behaviours.	• Child/young person beyond parental control – regularly absconds from home and is at risk of significant harm. • Failure or inability to address complex mental health issues requiring specialist interventions e.g. self-harm / suicidal attempts. • Young people with complicated substance misuse problems requiring specific interventions and/or child protection and who can't be managed in the community. • Puts self or others in danger – missing/at risk of sexual exploitation or other forms of exploitation.
Child or Young Person's Developmental Needs	**Child or Young Person's Developmental Needs**	**Child or Young Person's Developmental Needs**	**Child or Young Person's Developmental Needs**
	• Starting to show difficulties expressing empathy. • Can be over-friendly or withdrawn with strangers. • Can be provocative in appearance and behaviour.	• Failure or inability to address serious (re)offending behaviour leading to risk of serious harm to self or others. • Child/young person beyond parental control - regularly abscond from home and is at risk of harm. • Child/young person out of control in the community. • Difficulty coping with anger, frustration and upset. • Disruptive/challenging behaviour and unable to demonstrate empathy. • Regularly involved in anti-social/criminal activities. • Subject to discrimination – racial, sexual or due to disabilities. • Demonstrates significantly low self-esteem in a range of situation. • Is provocative in behaviour/appearance.	• Experiences persistent discrimination, e.g. on the basis of ethnicity, sexual orientation or disability. • Is socially isolated and lacks appropriate role models. • Alienates self from others. • Concerns about sexual exploitation or other forms of exploitation (including radicalisation; criminal exploitation; gang affiliation) • Child/young person is vulnerable following a period of being reported missing • Child under 13 years old engaging in sexual activity (Note: a child under the age of 13 is unable to give consent and therefore intercourse is deemed to be statutory rape).
Family and Social Relationships • Stable and affectionate relationships with caregivers. • Good core relationships with siblings. • Positive relationships with peers.	**Family and Social Relationships** • Some support from family and friends. • Has some difficulties sustaining relationships.	**Family and Social Relationships** • Has lack of positive role models. • Misses after school clubs or leisure activities. • Peers also involved in challenging behaviour. • Involved in conflicts with peers/siblings. • Regularly needed to care for another family member.	**Family and Social Relationships** • Periods of being accommodated by Local Authority. • Family breakdown related in some way to child's behavioural difficulties subject to physical, emotional or sexual abuse/neglect. • Social presentation.

Self-Care and Independence	Self-Care and Independence	Self-Care and Independence	Self-Care and Independence
• Growing level of competencies in practical and emotional skills, such as feeding, dressing and independent living skills. • Able to discriminate between 'safe' and 'unsafe' contacts. • Knowledgeable about sex and relationships and consistent use of contraception if sexually active (age appropriate).	• Slow to develop age appropriate self-care skills. • Early onset of sexual activity (13-14); sexually active young person (15+) with risk taking behaviours e.g. inconsistent use of contraception. • Low level alcohol/substance misuse (current or historical). • Some evidence of risky use of technology leading to E-safety concerns. • Not always adequate self-care – poor hygiene.	• Child suffers accidental injury because of inadequate supervision. • Child found wandering without adequate supervision. • Child expected to be self-reliant for their own basic needs or those of their siblings beyond their capabilities. • Severe lack of age appropriate behaviour. • Poor self-care for age – hygiene.	• Child is left "home alone" without adequate adult supervision or support and at risk of significant harm. • Distorted self-image and lack of independent living skills likely to result in significant harm. • Poor and inappropriate self-presentation. • Neglects to use self-care skills due to alternative priorities, e.g. substance misuse.

Response	Response	Response	Response
These children require **no additional support beyond that which is universally available**. An Early Help Assessment is not needed for these children. If needs are identified and can be met by the agency, any support/intervention offered must be recorded and maintained within the agency to capture & record needs.	In these circumstances agencies should maintain a record of all concerns, intervention and support on the agencies recording system. • If you require support to complete an Early Help assessment or convene a TAF meeting you should contact your local Targeted Early Help team (COG) for advice (see page 8)	An **Early Help Assessment** should have been completed with consent, and in collaboration, with the family/child/young person on the Early Help System to request a TAF Meeting. These will be triaged by SPOC Early Help staff. If additional services are required, then these will be coordinated through the Team Around the Family meeting and chaired by the Lead Professional. A bespoke package of support is required. A single assessment will be completed and a child in need plan developed	If following guidance from designated child protection leads within their agency or from an Integrated Services for Families and Young People social worker, it is agreed that there is a child protection concern and a referral to children's social care should be made, a professional must complete and submit a multi-agency referral form (MARF). A MARF must be completed and submitted within one hour. If a child is at imminent significant risk of harm/immediate danger (and reporting concerns cannot wait an hour while a MARF is completed) the referrer should call 999 for the Police or an Ambulance and also contact Sandwell Children's Social Care by telephoning the Contact Centre on 0121 569 3100 (24 hours). All MARFs will be screened by a qualified children's social care social worker who in conjunction with the Team Manager will assess whether the referral reaches the threshold to be considered by the multi-agency safeguarding hub (MASH). They will decide what course of action needs to be taken whether that be: strategy discussion; section 47 investigation; single assessment; step down to targeted services, single agency support or no further action.
***Examples of key agencies**	***Examples of key agencies**	***Examples of key agencies**	***Examples of key agencies**
• Education • Children's Centres • Nurseries • Police • Play Schemes • Health services • Voluntary and Community Services • Housing	• Police • Children's Centres • Education • Health Services • CAMHS • Voluntary and Community services • Housing	• Targeted Early Help Team (COG) • Other statutory services e.g. SEN Services • Specialist health or disability services (e.g. CAMHS) • Police • Voluntary and Community services • Services at Universal Level • Homelessness Services	• Children's social care • Other statutory services e.g. SEN Services • Specialist health or disability services (e.g. CAMHS) • Police • Integrated Services for Families and Young People • Voluntary and Community services • Services at Universal Level • Homelessness Services

*** Services may work across all levels of need**

Appendix 3: Contextual Safeguarding

Additional subject specific information about areas of risk to children, in both inter and extra familial circumstances

Understanding Child Exploitation	Recognising Risks	
You should always be alert to the possibility that a child/young person you are working with may be being exploited. This may be via being forced to supply drugs and/or commit offences for others who are controlling them. When considering possible exploitation you should first discuss the concerns with your agency's designated safeguarding lead and refer to CE indicators in the screening tool and risk assessment. There is no legal definition of 'county lines' or criminal exploitation. 'county lines' is used to describe situations where children may be trafficked within England for the purpose of criminal exploitation by urban gangs that supply drugs to suburban areas, market or coastal towns and/or other urban areas. Criminal exploitation includes activities such as using children to move drugs or money. A child or young person may not initially relay accurate information about their circumstances, particularly if they do not identify themselves as a victim, or if they are under the power and control of a perpetrator or group/gang. Within this context you need to think about why a child is reported as missing and the duration and frequency of missing episodes. Inappropriate relationship: the child/young person is in a relationship with an older partner who exerts a great deal of influence and control over them due to imbalance of power. The child/young person is likely to believe they are in a serious adult relationship and not recognise its exploitative nature. Peer exploitation: the child/young person is in a relationship with another child/ young person who is coercing them into sexual activity or other forced activity with their friends. This is the model that gang related exploitation follows. Organised exploitation: the child/young person is being groomed or sexually exploited by a network of perpetrators and may be being coerced into sexual activity or other forced activity with different people. Some children or young people may be used to recruit others.	The following are typical vulnerabilities in children prior to abuse: - Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality). - History of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour'-based abuse and violence, physical and emotional abuse and neglect). - Recent bereavement or loss. - Gang association either through relatives, peers or intimate relationships (in cases of gang associated CSE only). - Attending school with young people who are sexually exploited. - Learning disabilities.	The following signs and behaviour are generally seen in children who are already being exploited: - Missing from home or care. - Physical injuries. - Drug or alcohol misuse. - Involvement in offending. - Repeat sexually-transmitted infections, pregnancy and terminations. - Absent from school. - Change in physical appearance. - Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites. - Estranged from their family. - Receipt of gifts from unknown sources.

For more information: DfE guide to Child Sexual Exploitation (2017): Keeping Children Safe in Education Please see the SCSP website for further details and a CE risk assessment tool.	- Unsure about their sexual orientation or unable to disclose sexual orientation to their families. - Friends with young people who are sexually exploited. - Homeless. - Lacking friends from the same age group. - Living in a gang neighbourhood. - Living in residential care. - Living in hostel, bed and breakfast accommodation or a foyer. - Low self-esteem or self-confidence. - Young carer.	- Recruiting others into exploitative situations. - Poor mental health. - Self-harm. - Thoughts of or attempts at suicide.

Understanding Honour Based Abuse and Forced Marriage	**Recognising Risks**
Forced marriage is a Crime under the Anti-social Behaviour, Crime and Policing Act 2014. There is a clear distinction between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage, but the choice of whether or not to accept the arrangement still remains with the prospective spouses. However, in forced marriage, one or both spouses do not consent to the marriage but are coerced into it. Duress can include physical, psychological, financial, sexual and emotional pressure. In the cases of some vulnerable adults and young people who lack the capacity to consent, coercion is not required for a marriage to be forced. The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members, regardless of gender or sexuality. The	health problems including self-harm and eating disorders, reports to the police of domestic abuse, harassment or breach of the peace at the family home and a family history of early and forced marriage of siblings and running away from home. A full list of indicators can be found at p13 of The Right to Choose (published 2014), multi-agency statutory guidance for dealing with forced marriage. For more information: The Forced Marriage Unit, Foreign and Commonwealth Office (FCO) Telephone: 020 7008 0151 Email: fmu@fco.gov.uk

abuse can encompass, but is not limited to: psychological; physical; sexual; financial and emotional abuse. If families have to resort to violence or coercion alluded to above to make someone marry, that person's consent has not been given freely and it is therefore considered a forced marriage. Where a child/young person lacks the capacity to consent, an offence is also capable of being committed by any conduct carried out with the purpose of causing the victim to marry, whether or not it amounts to threats of violence or any other form of coercion.	Email for outreach work: fmuoutreach@fco.gov.uk Karma Nirvana helpline: 0800 5999 247 email: info@karmanirvana.org.uk West Midlands Police website: Honour Based Abuse page
Understanding Female Genital Mutilation (FGM)	**If FGM is observed or disclosed by an under 18 year old there is a statutory duty to report this.**
FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. FGM involves procedures that include the partial or total removal of the external female genitalia. FGM is a complex issue, and individuals and families who support it give a variety of justifications and motivations for this. FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women's sexual and reproductive rights. FGM is prevalent in 30 countries; these are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East, and in some countries in Asia. The prevalence of FGM in England and Wales is difficult to estimate because of the hidden nature of the crime. It is estimated that approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM. Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM.	For the purpose of the criminal law in England and Wales, FGM is mutilation of the labia majora, labia minor or clitoris. Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl or woman being at risk of FGM, or already having undergone FGM. There are a range of potential indicators that a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators present this could signal a risk to the child or young person. These indicators can be found at Annex B of the Multi-agency statutory guidance on female genital mutilation published in April 2016. Professionals should also note that the girls and women at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject. If you are concerned that a girl is at significant or immediate risk of harm. This must be shared with MASH and/or the Police. If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency. **For more information:**

	Sandwell policy and procedures to address female genital mutilation NSPCC FGM Helpline: 0800 028 3550 email: fgmhelp@nspcc.org.uk
Understanding Radicalisation	**What is "Prevent"?**
Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism which may lead them to conduct acts of terrorism. There is no obvious profile of a child/young person likely to become involved in extremism or a single indicator of when a child/young person might move to adopt violence in support of extremist ideas. The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame. Children/young people may be vulnerable to a range of risks as they pass through adolescence. They may be exposed to new influences and potentially risky behaviours, influence from peers, influence from older people or the internet/social media as they may begin to explore ideas and issues around their identity. There is no single driver of radicalisation, nor is there a single journey to becoming radicalised. The internet/social media creates more opportunities to radicalise individuals. It is a global 24/7 medium that allows children and young people to find and meet people who share, influence and reinforce opinions. The internet and face-to-face communications may work in tandem, with online activity allowing a continuous dialogue to take place.	Prevent is designed to support people who are identified as at risk of joining extremist groups and carrying out terrorist activities. It is one of four strands of the government's CONTEST counter-terrorism strategy. Through our Prevent work we aim to identify children who are at risk of contributing towards violent extremism and provide access to appropriate interventions. Prevent addresses radicalisation to all forms of terrorism, including the extreme right-wing, for example, and the non-violent, which can popularise views that terrorists exploit. For more information: Prevent Guidance national updated guidance issued in 2015.
Children and Young People: Possible signs of radicalisation	**What is Channel?**
The child/young person may exhibit the following behaviours: - Views become increasingly extreme regarding another section of society. - Observed downloading, viewing or sharing extremist propaganda from the internet. - Become withdrawn and focused on one ideology. - Talking as if from a scripted speech. - Become increasingly intolerant and/or disrespectful of others.	Channel is part of the Prevent programme. It is a multi-agency process for identifying, referring and supporting a person at risk of radicalisation, focusing on early intervention and engagement. Through Channel we aim to: - Identify people at risk of being drawn into terrorism - Assess the nature and extent of the that risk; and

- Change their appearance; their health may suffer (including mental health). - Become isolated from family, friends, peers or social groups. - Express a desire/intent to participate in or support extremist activity. - Increased levels of anger. It is important to note that some of the indicators described above are not specific to radicalisation and may point to something else that is worrying the child/young person.	- Develop the most appropriate support plan for the individual or individuals concerned.

Appendix 4: What makes a good referral

1.1. Whether making a referral for targeted services or completing the multi- agency referral form (MARF) the details of the referral make a difference to the timeliness of our intervention and the quality of our work with children, young people and their families. Guidance is also available on the Sandwell Children's Safeguarding Children Partnership website (https://www.sandwellcsp.org.uk).

1.2. When you have completed your referral, it may help for you to ask yourself the following questions:

1. **Does the person with parental responsibility know that I am concerned about their child and that I am making a referral? Have they consented to the referral being made?**
   Why? The 2004 Children Act is clear that consent should be sought wherever possible. In some cases, you will have concerns that a child is at risk of significant harm and parental consent is not forthcoming. In these cases, you should state on the referral what action you have taken to try to gain consent. In some rare cases your professional view will be that seeking consent will increase the risk to the child. This may include the risk of forced marriage or female genital mutilation. In these cases, state, clearly on the referral form why you have not sought consent.

2. **Have I included all the personal details I have about the child / young person and their family?**
   Why? These details including DOB/ethnicity/telephone numbers/up to date address/ language and a family composition mean that the child's records can be accessed quickly, and that any intervention can be provided in a timely way. Phone numbers mean that families can be contacted quickly. Where English is not a first language details will allow the provision of an interpreter.

3. **Have I included details about any other practitioners working with the family?**
   Why? Knowing these details, especially if there has been a TAF, will ensure that their knowledge and skills be part of the assessment and intervention.

4. **Have I made it as clear as possible what I am concerned about?**
   Why? Making it clear what you are concerned about helps Sandwell Children's Services in their decision making. Sometimes you may not be absolutely certain about what is happening for the child/ young person. In these cases, provide as much

detail as possible. Remember that you have professional expertise and will be up to date with research and practise in your field of work. Try to reduce the use of jargon and provide some analysis. For example: as a health practitioner, you may be concerned about failed appointments or concealed pregnancy; as a teacher, you may be concerned that a child's changed behaviour and demeanour is affecting their learning. Setting out what this means for the child and the impact on their development will ensure that the assessing social worker or targeted practitioner (who will not have the same level of expertise in your area) understands your perspective and can include this analysis in their assessment.

5. **Have I made it clear what I have done already and what worked or didn't work?**
   Why? Research tells us that we sometimes 'start again' with families. This is especially the case where there is chronic neglect or with families who appear compliant with plans but fail to either follow through with work or fail to sustain change. Knowing what has been worked well enables targeted and social work services to build on success; knowing what has failed to sustain change ensures that this can be explored, and other solutions sought.

6. **Have I made sure that I will be available for further discussion about the referral and how I can be contacted?**
   Why? As the referrer, you are the person with the most up to date knowledge of the child/ young person and we want you to be involved in our decision making and intervention. We aim to make a decision on every referral within 24 hours. If you cannot be available, please provide the name and contact details of someone familiar with the child and your concerns who can act for you. You will receive feedback on your referral.