BSCB Bristol Safeguarding Children Board
making safeguarding everybody's business

BRISTOL SAFEGUARDING ADULTS BOARD

Joint BSCB and BSAB Multi-Agency Guidance

SAFEGUARDING CHILDREN, YOUNG PEOPLE AND YOUNG ADULTS WITH DISABILITIES

January 2018

The voice of children, young people and adults, parents and carers in Bristol.

This consultation was supported by young people from WECIL (West of England Centre for Inclusive Living) and young people with sensory impairments that work with CCHP (Children's Health Partnership Bristol Community Health). This is their feedback.

What makes Children and Young Adults with a disability feel more able to cope:

- **Being listened to and what I say making a difference to what happens;**
- **People giving me enough time to speak and prepare for meetings;**
- **When people are kind to me and get to know me;**
- **When things don't change suddenly and the people who support me stay the same;**
- **Living with my family;**
- **Being with my friends;**
- **Using my communication aid as much as possible;**
- **Having time to go on trips;**
- **Having access to controls such as the TV remote;**
- **People thinking about what they say before they say it;**
- **Helping my parents understand I can be independent;**
- **People giving me enough time to answer;**
- **Talking to me about relationships and things I want from my life;**
- **Spending time at youth groups.**

What makes Children and Young Adults with a disability feel WORRIED:

- **Change;**
- **My Communication aid (VOCA) not being charged or not working;**
- **Not knowing about things that may happen;**
- **Too many people around me;**
- **New people helping me;**
- **Not having enough support;**
- **My mum/carer not coping;**
- **People not learning how to communicate with me;**
- **Things happening that I was not expecting;**
- **I get scared when there are lots of people at meetings talking about me, I don't feel like I am there;**
- **Not knowing who everyone is at meetings that are about me;**

- My Social Worker changing, I really like them. They help me and my family;
- Some professional haven't listened to me before. I have moved schools so many times and this makes me feel angry. People need to listen more and take time to speak to me and build a relationship with me;
- Bullying;
- My family being ill;
- Being lonely;
- Too much pressure on me now I am getting older;
- People making assumptions about what I can and can't do;
- Managing the public transport system;
- Not knowing if I'll be able to get a job when I'm older;
- Worrying what will happen to me if my dad/carer gets sick again;
- Talk to me not to my support worker

What could people do to HELP you:

- More 1:1 support;
- Give us more choice;
- Having access to Social Media using my communication aid (VOCA);
- Time to have more fun with friends;
- Making sure my Communication aid (VOCA) is always with me;
- More support for independent living;
- More CCTV in schools;
- Having time and having the equipment to e mail and text;
- Letting us know what to do at every stage;
- Knowing who are my Trusted Adults;
- Teaching me how to use my phone and computer safely;
- Don't talk to us like children, I would speak more;
- Have different ways to communicate – talk to people who know us well beforehand about how we communicate best;
- Try and use short words to help us understand;
- Talk more to parents and carers but include me in the conversations;
- Don't force me to speak; I will speak to the person when I want to;
- Recognise some impairments are hidden.

What MORE could be done to help Parents and Carers:

- One person to coordinate all the professionals around us;

- **Be patient, at any one time we could be working with over 20 different professionals;**
- **Make everything easier for us by explaining everything;**
- **Good policies and procedures to keep our children safe when our children are not with us;**
- **Understand the pressure that we are under;**
- **Help us and support us through processes we don't understand;**
- **Provide good information that is easy to understand;**
- **Make things more accessible;**
- **Listen more to our children and take the time to do so;**
- **Eliminate the barriers that we all face such as accessible areas and more places to go;**
- **Recognise the needs of our other children.**

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Introduction

Safeguarding children, young people and young adults is everyone's responsibility especially because their vulnerability makes them more susceptible to all forms of abuse than people without impairments.[1] It is important that professionals identify low level risks and ensure that they are managed through multi agency early support so there is early intervention and prevention to minimise the risk and harm that could occur. Professionals and volunteers in all agencies should be alert to the specific indicators that may suggest abuse in this particular group of vulnerable children, young people and young adults and how to follow the referral pathways.

Protecting disabled children: thematic inspection report reviewed the effectiveness of child protection work for children with disabilities in several Local Authorities and whilst it found that children and their families receive good multi-agency early support, too many children had child protection needs which went unidentified. A well-defined, robust, timely and coordinated multi-agency response is always required and the unique needs of children, young people and young adults with impairments are recognised, identified and the necessary adjustments are made at all stages of the safeguarding process in order that they are best protected.

[1] https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-report.pdf

"Children, young people and young adults who live with a physical, sensory, intellectual or mental health disability are in greater need of support and protection and find themselves at significantly increased risk because of physical vulnerability, communication difficulties and lack of knowledge of human rights. It is vital that professionals and volunteers across the City of Bristol work together to ensure that our safeguarding roles involve prevention, recognition, protection and support at the earliest opportunity."

Sally Lewis (BSCB) and Louise Lawton (BSAB)

Independent Chairs of Bristol Safeguarding Children and Adult's Board.

Purpose of Guidance

The Equality Act 2010 ensures that the same level of safeguarding is received by people as with any other person without a disability. The Act eliminates the discrimination and the harassment that relates to impairment and promotes positive attitudes that include ensuring public authorities are aware of their duties. It states that:

'A person has a disability if she or he has a physical or mental impairment and the impairment has a substantial and long term adverse effect on his or her ability to carry out normal day-to-day activities.'

The Equality Act 2010

This multi-agency guidance includes children, young people and young adults up to and including the age of 25 who have an impairment including sensory impairment and learning difficulties. The purpose of this guidance is to ensure that:

- The child, young person, and young adult's voice is heard;
- Raising awareness of the safeguarding risks/ indicators of abuse for people with an impairment (0-25);
- Gives guidance to **ALL** practitioners and managers working with people with a disability (0-25);
- Provides research evidence about the vulnerability of children and adults with disabilities to abuse;
- Early identification and thorough assessments for children, young people and young adult's and their families;
- Ensures that the need for expertise in both safeguarding and promoting the welfare of the child, young person and young adult in relation to impairment is recognised, understood and brought together in order that they receive the same levels of protection from harm;

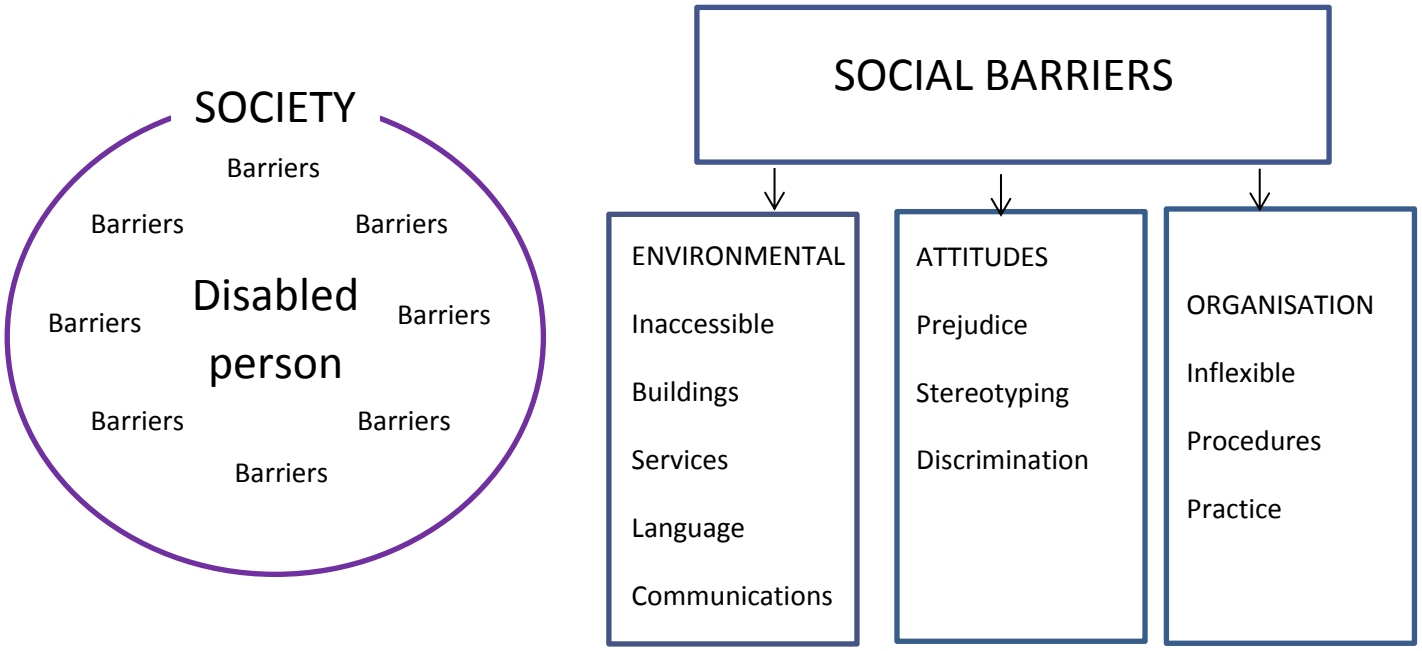
- Addresses the importance of professionals taking collective responsibility for responding effectively to concerns;
- Makes clear the critical importance of communication with people with disabilities including recognising that everyone can communicate if they are asked in the right way by people who understand their needs and have the skills to listen;
- To incorporate learning from Serious Case Reviews to ensure all agencies recognise that safeguarding and promoting the welfare of disabled children depends on effective information sharing, collaboration, shared expertise and understanding between agencies and professionals;

It's harder to make yourself heard at times. You can't communicate easily, because of whatever problem and need to be given time to speak. We need people that speak to us to listen."

Child who works with Bristol Charity WECIL

Social Model of Disability

This model refers to the way in which society discriminates against people who have physical or sensory impairments, learning difficulties or emotional distress. It recognises that children and adults with disabilities face prejudice and discrimination and are excluded from mainstream activity. It seeks to locate the problem with society rather than the individual. It seeks to inform and alter society's structures, physical environment and attitudes to develop equality of opportunity for disabled children and adults. This model's principles of choice, rights and empowerment are fundamental to good practice in working with children, young people and young adults with disabilities.



People with disabilities developed this model because the traditional medical model did not explain their personal experience of disability or help to develop more inclusive ways of living. In 2014 the social model was endorsed by the Government Equalities Office who recommended the model for use by all government departments in the way they interact with people with disabilities.[2]

Medical Model of Disability

The medical model sees the person's impairment or health condition as 'the problem'. The focus is therefore on 'fixing' or 'curing' the individual. Aspects of the Equality Act 2010, in relation to disability discrimination, follow the medical model of disability as they focus on what a person is unable to do.[3]

You will see from the table beneath examples of differences between the two models. This shows that society is generally somewhere on the spectrum between the two models. For an assessment, professionals should use the one used within their agency.

Issue	Medical Model	Social Model
Education	Disabled children receive specialist provision in special schools and are entered for alternative qualifications	Disabled children are educated in accessible mainstream schools alongside non-disabled children. Education provision is accessible to all with the same qualifications and opportunities open to all who wish to access them.

[2] https://www.ombudsman.org.uk/sites/default/files/FDN-218144_Introduction_to_the_Social_and_Medical_Models_of_Disability.pdf
[3] [3] https://www.ombudsman.org.uk/sites/default/files/FDN-218144_Introduction_to_the_Social_and_Medical_Models_of_Disability.pdf

Prevalence Data

Children with Disabilities are:

3.4 times more likely to be abused or neglected
3.8 times more likely to be neglected
3.8 times more likely to be physically abused
3.1 times more likely to be sexually abused
3.9 times more likely to be emotionally abused
(Sullivan & Knutson 2000

Meta-analysis of 17 studies of violence against children:
Disabled children are 3/4 times more likely to experience violence
26.7% experience more than one form of violence in their lifetime
20% physical violence
14% sexual violence
Emotional abuse is "comparable" to violence
(Jones et al. 2012)

Young adults with Disabilities:

The systematic review on violence against adults with disabilities, published in February 2012, found that overall disabled adults are 1.5 times more likely to be a victim of violence than those without a disability, while those with mental health conditions are at nearly four times the risk of experiencing violence.

(Hughes et al 2012)

Regional research in Liverpool found that 80% of respondents – all were people with autism or their families speaking on their behalf – had been bullied or taken advantage of by someone they considered a friend. In addition, 71% had been subject to name calling and verbal abuse and 54% of 12-16-year-olds had had money or possessions stolen. The survey found the most vulnerable age group to be 16-25

(Vasey 2012)

A national survey by the National Autistic Society (NAS) in 2014 found 49% of adults with autism reported that they had been abused by someone they thought of as a friend (MATE crime).

Vulnerability of children, young people and young adults with a disability

Children, young people and young adults with disabilities are vulnerable for a number of reasons:

- Less likely to receive sex education or information about their own bodies;
- Use different communication systems and may not have the language skills to disclose;
- May be unable to distinguish between types of touch;
- Have less choice in everyday life;
- Don't believe their wishes will be listened to;
- Don't believe they can control things;
- More isolated physically and socially from mainstream services;
- Have more dependency on parents and carers for practical assistance in daily care including intimate personal care, increasing risk of exposure;
- Be exposed to more carers, professionals and volunteers (including in residential and short break settings);
- Have an impaired capacity to resist or avoid abuse (e.g. restricted mobility or a communication barrier);
- Are subjected to an increased inequality of power;
- Need to be assisted with movement;
- Lack of support and training for parents and carers in managing difficult behaviour;
- An assumption that behaviour is an integral part of the child's condition rather than a response to pain, abusive treatment and/ or a negative reaction to medication;
- Multiple carers and different settings;
- Many disabled children and young adults are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled people;
- Especially vulnerable to bullying, intimidation hate and mate crime.

Looked after children, young people with disabilities are not only vulnerable to the same factors that exists for all children living away from home and adults but are susceptible to possible abuse because of their additional dependency on residential, short break and hospital staff for day to day care needs. Similarly, this applies to young adults with disabilities in care settings

It is important to remember that siblings may be particularly vulnerable as their needs and wishes can be sometimes be overlooked when there more are complex needs.

Features of abuse for children, young people and young adults

Whilst children and young adults with a disability experience the same types of abuse as others they can be more vulnerable. This list is not exhaustive and includes offences against children and adults. What constitutes abuse or neglect can take many forms and the circumstances of the individual case should always be considered. For specific local multi agency guidance refer to the Bristol Safeguarding Adult's Board and Bristol Safeguarding Children websites. For Regional Guidance (that has links to National Guidance) refer to South West Child Protection Procedures (SWCPP) for children.

Types of abuse include:

Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic abuse – including psychological, physical, sexual, financial, emotional abuse and so called 'honour' based violence. This can include controlling, coercive and threatening behaviour.

Sexual abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Sexual exploitation- involves exploitative situations and relationships where people receive 'something' (e.g. accommodation, alcohol, affection, money) as a result of them performing, or others performing on them, sexual activities. Key features include coercion and control, disclosures and retractions.

Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, or unreasonable and unjustified withdrawal of services or support networks.

Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements(including in connection with wills, property, inheritance or financial transactions) or the misuse or misappropriation of property, possessions or benefits.

Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude, and inhumane treatment. A large number of active organized crime groups are involved in modern slavery but it is also committed by individual opportunistic perpetrators. Someone is in slavery if they are:

- Forced to work (through mental or physical threat)
- Owned or controlled by an 'employer'(usually through mental or physical abuse, or the threat of abuse)
- Dehumanised, treated as a commodity or bought and sold as 'property'
- Physically constrained or has restrictions on his or her freedom of movement.

Contemporary slavery takes various forms and affects people of all ages, gender and races.

Human trafficking involves an act of recruiting, transporting, transferring, harbouring or receiving a person through use of force, coercion or other means for the purpose of exploiting them.

Criminal Exploitation and County Line Activity - Criminal exploitation of children and vulnerable adults is a geographically widespread form of harm that is a typical feature of county lines activity. It is a harm which is relatively little known about or recognised by those best placed to spot its potential victims.

County lines is the police term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines or "deal lines". It involves child criminal exploitation (CCE) as gangs use children and vulnerable people to move drugs and money. Gangs establish a base in the market location, typically by taking over the homes of local vulnerable adults by force or coercion in a practice referred to as 'cuckooing'. This is a cross-cutting issue involving drugs, violence, gangs, safeguarding, criminal and sexual exploitation, modern slavery, and missing persons. For specific advice please consult Home Office guidance Criminal Exploitation of children and vulnerable adults: County Lines guidance.

Discriminatory abuse – including forms of harassment, slurs or similar treatment because of race, gender, gender identity, age, disability, sexual orientation or religion. This includes hate and mate crime. **Mate Crime** is where people with disabilities have so called 'friends' who go on to abuse them. This has led to financial, physical and sexual abuse, people losing their independence and sometimes even murder. Whilst Mate Crime is not defined in the Care Act it is important that professionals are aware that these so called friendships could be an indication that a person with a disability is being targeted. 'Mate Crime' is a term used to describe the relationship the perpetrators had with their victim. In the Serious Case review of Gemma Hater (2010), and it was argued in the Serious Case Review of Steven Hoskins (2007), that the term 'disability hate crime' failed to recognise the duration of

Steven's contact with his persecutors and referred to it as a 'counterfeit friendship.' In a national survey by the National Autistic Society (NAS) in 2014, 49% of adults with autism reported that they had been abused by someone they had thought of as a friend.

Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Neglect and acts of omission – including ignoring medical, emotional or physical care needs; failure to provide access to appropriate health, care and support or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating

Self-neglect – This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Forced Marriage - a marriage in which one or both of the parties is married without their consent or against their will. In a situation where there is concern that an adult is at risk of being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the Safeguarding Adults process.

Female Genital Mutilation (FGM) - FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences; including mental health problems, difficulties in childbirth causing danger to the child and mother, and/or death. It is illegal in England and Wales under the Female Genital Mutilation Act 2003.

As amended by the Serious Crime Act 2015, the Female Genital Mutilation Act 2003 now includes:

- An offence of failing to protect a girl from the risk of FGM;
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK;
- Lifelong anonymity for victims of FGM ;
- FGM Protection Orders which can be used to protect girls at risk, and
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

Prevent – Preventing radicalisation to extremism. -The Prevent strategy forms part of the UK's Counter Terrorism and Security Act (2015), Its key objective is to challenge the ideology that supports terrorism and those who promote it; therefore preventing people from being drawn into terrorism and work being undertaken with 'specified authorities' where there may be risks of radicalisation.

The scope of the Prevent Duty covers terrorism and terrorist related activities, including domestic extremism and non-violent extremism. The aim is to work with partner agencies (primarily the police) to divert people away from what could be considered to be linked to terrorist activity.

Prevent defines extremism as: "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces".

Radicalisation is defined by the UK Government within this context as "the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups."

Channel is a multi-agency programme which provides support to individuals who are at risk of being drawn into terrorism. Channel provides a mechanism at an early stage for assessing and supporting people who may be targeted / radicalised by violent extremists.
https://www.gov.uk/government/publications/channel-guidance

Bristol's partnership approach to Prevent is co-ordinated by Building the Bridge (a Multi-Agency partnership). **Police Prevent Team** – Telephone **01278 647466** or 101 (and ask for the 'Prevent Team') **Email** channelsw@avonandsomerset.police.uk

IMPORTANT
Features of abuse particular to children, young people and young adults with disabilities could be:

- Failure to provide treatment or providing inappropriate treatment;
- Not allowing adaptations or equipment a child might need;
- Threats of abandonment/ exclusion;
- Exclusion for example, from family events, over use of 'short breaks, unnecessary schooling away from home, depriving of visitors etc.
- Not feeding enough (to keep a person light for lifting);
- Lack of stimulation;
- Unjustified and/or excessive use of restraint;
- Rough handling,
- Extreme behaviour modification e.g. deprivation of liquid, medication, food or clothing;
- Unwillingness to try to learn a child's or adult's means of communication;
- Ill-fitting equipment e.g. callipers, sleep boards, splints;
- Misappropriation of a child's finances;
- Invasive procedures which are unnecessary, or which are carried out against the person's will(if it is not considered to be in their best interests);Insufficient time given to feed or hydrate a person;
- Inappropriate restraint;
- Inappropriate sanctions;
- Intimidation;
- Verbal abuse;
- Removal of batteries from a child's wheelchair to restrict mobility;
- Locked in a room.

Possible indicators of abuse

All practitioners need to be aware of the possible indicators of abuse. It is not always apparent when a child without disabilities has suffered significant harm. Where there are safeguarding concerns involving children young people or young adults with disabilities there is a need for greater awareness of the possible indicators of abuse and / or neglect. because the situation and barriers to obtaining a clear picture can be complex. It is **crucial** that the difficulties that are present do not deter an investigation. Any safeguarding concerns for children and adults with disabilities should be acted upon in the same way set out for a non-disabled child as per local procedures and guidelines. When considering whether the threshold for a safeguarding enquiry has been met, impairment needs should be taken into account. In addition to the universal indicators of abuse/neglect for children

and adults, the following abusive behaviours must be considered as they could be some of the indicators of abuse or neglect:

- A bruise in a site that might not be of concern on an ambulant person;
- Malnourishment;
- Regression on toileting behaviour (incontinence soiling). New episodes of wetting or soiling;
- Pressure care (pressure sores);
- Something that is recognised by the professional , volunteer, parent or advocate that knows the person with the disability as being unusual or different;
- Changes to behaviour or emotional wellbeing – shift in what is normal– tearful quiet etc;
- Change in sleep pattern or eating.

There are many indicators so it is important to keep an open mind and ensure the danger of attributing indicators of abuse to the child, young person or young adult's impairment is avoided.

EXAMPLE

A child with learning difficulties, limited communication and eczema had red marks on his arms and legs. These were in fact due to him being tied into his buggy but were misinterpreted as being due to the eczema. In another case, bruising to the thighs and anal area was assumed to be associated with the administration of rectal Valium but was in fact caused by sexual abuse (Edwards and Richardson 2003, p.33)[4]

Reasons for under reporting by children, young people and adults

There are many reasons why children, young people and adults do not report abuse due to the barriers that are available. These could be;

- Communication difficulties;
- Dependency on abusers;
- Fear of services being withdrawn;
- Not having the opportunity to tell;
- Unaware that what they are experiencing is abuse;
- Lack of peer support;

[4] Edwards, H. and Richardson, K. (2003) The child protection system and disabled children. In *"It Doesn't Happen to Disabled Children": Child Protection and Disabled Children. Report of the National Working Group on Child Protection and Disability*.

- Belief that it is a justifiable accident;
- Self-blame;
- Lack of self-worth/desensitisation;
- Fear;
- Threat of reprisal from abuser;
- Adult power or coercion;
- Adult collusion;
- Fear of not being believed;
- Unaware of rights;
- Not being asked or talked to;
- Age or material appropriate to developmental lacking to inform children, young people and young adults about the different types of abuse.

Duty of organisations and professionals in overcoming the barriers

Organisations must ensure that arrangements are in place to minimise the likely impact of these vulnerabilities on children, young people and adults with disabilities with a particular focus on prevention. They **must**:

- Ensure there is a focus on prevention;
- Ensure that the required policies and procedures are in place in relation to;
    1. intimate care guidelines,
    2. managing behaviour that challenges families and services,
    3. issues around consent to treatment;
    4. anti-bullying and inclusion strategies;
    5. sexuality and safe sexual behaviour among young people;
    6. monitoring and challenging placement arrangements for young people living away from home;
- Ensure that staff are trained appropriately where a child/young person is cared for away from home ensuring they have access to an independent advocate;
- Promote children and young people's right to safeguarding;
- Ensuring children and young people have access to information and their basic right to communicate is always met;
- Access to information about strategies for keeping safe that is usually available to other children and young people;
- Ensure staff are aware of the warning signs of fabricated or induced illness.

Communication

"All children can communicate something and [professionals] shouldn't ever dismiss the possibility of getting information from children if you find the right way."

(Stalker et al 2010)

Reluctance to engage with children and young adults with disabilities is likely to be based on a lack of confidence, knowledge and experience. Training is needed for police, education and social work staff in terms of communicating with disabled children, especially those with communication impairments. Augmentative or alternative communication (AAC) is the term used to describe different methods of communication that can be used to add to the more usual methods of speech or writing when these are impaired. There are many different formats:

- Signing and gesture;
- Picture boards
- Braille
- Computer based methods
- Sounds

Professionals working with the child can provide advice and support for disabled children/young people and may be able to advise on a range of access issues. It is important to involve professionals who know the child well. Deaf children may need an independent sign language interpreter. Due regard needs to be given to the fact that whilst some children are more likely to communicate with a familiar person any such familiar person is equally in a position to influence or abuse the child.

All reports that are written about a child, young person or young adult should include their views, wishes and feelings, and how they have been ascertained. Best practice for a child with disabilities is for a worker with appropriate communication skills to be allocated**.** Workers must identify barriers to access services and must aim to make information provided available to children/young people and their parents. This information should take account of the child/young person's impairment, the child/young person's and parents' preferred formats and be made available within agreed time frames.

When communicating with a child, young person or young adult it is important to keep an open mind and to consider a child's ethnicity, cultural and religious background, acknowledging when you don't understand. **Never give up**, pay attention to verbal and non-verbal communication and take time to communicate with a combination of methods if required.

Participation

Participation requires a culture of inclusion right across all services and management to promote ongoing involvement and empowerment. It involves not just the opportunity to contribute a view but also;

- Preparation;
- Provision of information;
- Consultation, discussion and negotiation;
- Explanations and feedback;

all in formats easily understood by children, young people and adults and /or their parents.

Participation at meetings/reviews can take the format of physical attendance at meetings but it is not limited to this. For some people attending meetings may be extremely stressful. There are many other ways a child, young person or young adult may wish to express their views and wishes and feelings in reviews; from briefing others as their advocates or through

the use of IT /video/artwork, or for very young children or children with disabilities emotional responses - a method sometimes overlooked (though often open to individual interpretation).

Special communication systems include Braille, and different forms of sign language (e.g. Makaton, Widget, and Picture Exchange Communication Systems.) It is unlikely that all chairs will be skilled in all of these methods of communication but it is essential that they ensure people skilled in these areas are able to input their views.

Safeguarding Concerns – Initial contact and referral

Concerns about the welfare of a person with disabilities should be acted upon in the same way as any other child or adult at risk. However, in addition, specific expertise and resources in safeguarding and promoting the welfare of children and adults have to be brought together. This will ensure that people receive the same levels of protection from harm.

The following approach described by Yasmin et al. (2016) should be taken: [5] This can be taken for adults as well as children.

Rule 1 – Take children seriously;
Rule 2 – Act quickly;
Rule 3 – Make notes and always keep them and store them securely as they may be needed in an investigation;
Rule 4 – Think the unthinkable;
Rule 5 – Don't wait to be certain;
Rule 6 – Share Information correctly.

A referral should be child/person focused and comprehensive, it must include as much information as possible such as any significant events, the views or wishes of the child/young person or adult, chronologies and completed body maps detailing any physical injuries. A comprehensive referral will contribute to a thorough assessment that supports professionals to understand whether a child, young person or adult has needs relating to their care or impairment and/or is suffering or likely to suffer significant harm (if a child), or is experiencing or at risk of experiencing, abuse or neglect(if an adult). Additionally the referral should include information on whether the person and their family/carers have received support through the early help provision and provide an evaluation of the impact of services and help being delivered.

Expertise and resources in both safeguarding and promoting the welfare of children, young people and young adults and in working with disability have to be brought together to

[5] http://www.paediatricsandchildhealthjournal.co.uk/article/S1751-7222(16)30101-9/fulltext

ensure that the person receives the same levels of protection from harm as others. In accordance with procedures, specialist workers or teams must be notified of the referral and included in any investigative process. At the earliest opportunity it MUST be decided which team will take the referral and extra resources allocated, especially when there are language and communication needs. An accurate assessment of the child or adult's understanding and language abilities with input from their parent, teacher and/or speech and language therapist is essential.

Case Study

JACK'S STORY

Jack is 7 years old. He has bilateral cerebral palsy and is dependent on other people and his wheelchair for all mobility and transfers.

He has a number of bruises on his legs.

Considerations:

- Can Jack tell his own story? What help may be needed to facilitate this? For example, from the specialist speech and language therapist who knows him best.
- Does the story match the bruises in severity, location, type and pattern?
- Bruising on non-mobile children are much less likely to be accidental. Jack doesn't run about and fall over like non-disabled 7-year-olds. These bruises are worrying and need further investigation.
- Jack's equipment: could straps or splints account for the bruises?
- Jack's health conditions, known or yet to be diagnosed. Does he have seizures causing him to bang his legs against equipment?
- Does he have an undiagnosed clotting disorder requiring further investigation and expert opinion?
- Jack's various places of care and range of carers. Does anyone involved have information on how the bruises occurred?
- Whenever there are unanswered questions and abuse is a possibility in the differential diagnosis, then a referral to social care is essential, so that robust enquiries can be made in the child's best interests.

Children and Families Service

There will be joint-working at an early stage and joint care planning. This should include regular multi-professional meetings, information sharing and all agencies contributing to a streamlined plan where appropriate. First Response is the front door to children's services in Bristol. They should be contacted if there is a safeguarding or child protection concern about a child or young person (under the age of 18), or if an offer of Early Help is required.

Single Assessment Framework

The Single Assessment framework (SAF) is part of a framework for joint and multi-agency working for all children, young people and families with additional needs. It can also be considered for young adults in the transitional phase of services. This Single Assessment Framework can be used for a referral that is at Early Help, Child in Need (Section 17 Children Act 1989) or the Child requiring Protection (Section 47 Children Act 1989) stage. These stages of need and protection are set out in the Threshold Guidance. The Threshold Guidance which describes the steps when professionals are determining if the criteria is met for a statutory intervention in family life, or when professionals are considering if a child should be receiving a specific type of support. It is also used for a transition between different levels of needs and types of services.

It is important that Children with disabilities have access to Universal services as well as targeted services where appropriate, before they are dealt with by specialist services.

For children with protected characteristics under the Equality Act 2010, assessments should address the impact that discrimination may have on a particular child and their family and ensure that the assessment process itself does not reinforce discrimination. Please note:

- All children, irrespective of any protected characteristics, can potentially be subject to abuse and neglect;
- The assessment process should maintain a focus on the needs of the individual child and should include any needs associated with protected characteristics;
- Cultural factors neither explain nor condone acts of omission or commission which place a child at risk of significant harm; all children have a right to grow up safe from harm;
- Professionals should guard against myths and stereotypes of black and minority ethnic families, children with disabilities and lesbian, gay and bisexual young people.
- Anxiety about being accused of discriminatory practice should not prevent the necessary action being taken to safeguard a child;
- Abuse or neglect of a disabled child may be harder to identify, especially if the child has difficulty communicating, so professionals need to be vigilant when undertaking assessments;
- Professionals should be informed about differing family patterns and lifestyles, and to child rearing patterns that vary across different racial, ethnic and cultural groups;
- Professionals should be aware of the broader social factors that serve to discriminate against black and minority ethnic people, people with disability and lesbian, gay and bisexual people;

- Professionals need to understand the effects of harassment, discrimination and institutional discrimination, as well as cultural misunderstanding or misinterpretations.

In Bristol, we use the Signs of Safety methodology when working with children and families so we all know what is working well with children, what the strengths are, what we are worried about and what steps are we going to take to resolve matters. Where disagreement cannot be resolved, agencies are able to use the BSCB Resolution of Professional Disagreements.

Section 47 Enquiries

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm (see appendix 1) there should be strategy discussion with other agencies including health agencies, the police, education, social care and any other appropriate agency. Any complex issues relating to an impairment and the need for communication aids should be addressed. If it is likely that a medical examination is required, then a community paediatrician MUST attend the Strategy meeting. **A full medical examination in relation to suspicion of child abuse or neglect must only be carried out following the decision of a strategy discussion to conduct such a medical.** Where it has been agreed by the police and children's social care that it is in the best interests of the child that a full criminal investigation be carried out, the police are responsible for that investigation, including any investigative interview (video-recorded or otherwise) with the victim (recommendation 99 of the Victoria Climbie Inquiry Report).[6]

If a criminal investigative interview process is required then an assessment should be conducted to explore if the witness will be a competent witness and that their welfare needs are considered. **It is vital however that every effort is made to ensure that a child, young person or young adult with disabilities is treated the same as a witness without disabilities. It is the responsibility of the professionals involved that all attempts are made to ensure that any requirements needed in relation to communication should be considered including the need for an intermediary, interpreter or facilitator in augmentative communication.**

Crown Prosecution Service (CPS) Guidance states that; there is rarely any reason in principle why disabled children should not take part in a video-recorded interview, provided the interview is tailored to the particular needs and circumstances of the child. This will require additional planning and preparation by the interviewing team and a degree of flexibility in scheduling the interview. Particular attention will be needed to ensure that a safe and

[6] https://www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf

accessible environment is created for the child and that the interview suite is adapted to the child's particular needs. Disabled children are likely to have already come to the attention of professionals and therefore information is likely to be available from existing assessments and from workers who know the child well. Such information should enable the interviewing team to make an assessment of the likely impact, if any, of a child's impairment on communication. Where children have specific communication difficulties, aids such as drawings or photographs may need to be prepared to facilitate questioning. All such aids should be preserved for possible production at court.[7]

If the child witness progresses to Video Interview then Achieving Best Evidence Guidance should always be followed. This is guidance on interviewing victims and witnesses, and guidance on using special measures, which includes specific information in relation to disabled children. This assists those responsible for conducting video-recorded interviews with vulnerable, intimidated and significant witnesses, as well as those tasked with preparing and supporting witnesses during the criminal justice process. Furthermore, there are measures that should be made available and are detailed in the Youth Justice and Criminal Evidence Act (1999), with the introduction of intermediaries whose role is specifically introduced to address the barriers and therefore enable disabled children to give evidence.

Achieving Best Evidence Interviews with children, with disabilities

Interviews under Achieving Best Evidence can only be undertaken by suitably qualified social workers and police officers that have completed the required training. Interviewers need to be aware of differences between potential interviewees in their social, emotional and cognitive development, and in their communication skills, the degree of their understanding and in their particular needs. Specialist advice should be sought on what special procedures are appropriate and to consider if the services of an intermediary or an interpreter are required.

The guidance defines a child as up to and including the age of 17 but young people with disabilities are likely to be considered adults at risk and be eligible for additional support beyond 17. Not all young people with disabilities will necessarily be vulnerable as witnesses and would not wish to be treated as such. It is therefore important that the views of individual witness who might fall into this category are taken into account.

Particular attention will need to be taken to ensure that a safe and accessible environment is created for the child and that the interview suite is adapted to the child's particular needs.

[7] https://www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf

Where children have specific communication difficulties, aids such as drawings or photographs may need to be prepared to facilitate questioning. It is important to find out what impact the child's impairment is likely to have on the communication process, and to adopt a positive approach that focuses on the child's abilities when trying to find out how they can be helped to communicate.

The impact of any medication being taken by the child on the interview, including the most appropriate timing for it, should be taken into account. For some children, a number of shorter sessions may be preferable to a single interview. For example, children with learning disabilities often have shorter attention spans, giving rise to a need for regular and frequent breaks. In addition to this, some children with physical or learning impairments might find communicating to be quite demanding and this is also likely heighten the need for breaks and a slow pace, thus lengthening the duration of the interview(s).

Parental Responsibility, Gillick Competency and Fraser Guidelines

Children, young people and young adult's views should always be sought however the law assumes that before children reach the age of 16, that they are not able to make decisions for themselves and their parents will make decisions for them. This means that parents will routinely be asked to make decisions on behalf of their child or young person with an impairment; for example, what type of social care support is to be provided or whether proposed medical treatment should be given to their child. However, as children develop and mature, they will generally become more able to participate in decision-making and start to make their own decisions about their own care and support even before the age of 16. Where a decision may fall outside the 'scope of parental responsibility' an application to the High Court under its 'inherent jurisdiction' (or in the case of a young person who lacks capacity under the MCA 2005 to make the relevant decision, the Court of Protection) is likely to be required, for which specialist legal advice will need to be sought.

In cases where children are considered to have the necessary maturity and understanding to make the decision in question for themselves, they are often referred to as being '*Gillick competent*'. Where children are Gillick competent and have the capacity to make decisions their views should be respected in the same way as an adult's request for confidentiality. This means that confidential information may only be disclosed without the child or young person's consent if this can be justified, for example, there is a legal requirement to do so or there is reasonable cause to suspect that the child or young person is suffering, or at risk of suffering, significant harm.

The Mental Capacity Act 2005 (MCA)

The MCA (2005) applies to people **aged 16** and over. It is important that all those working with young people aged 16 and 17 are aware of this Act and its accompanying code of practice. Young people aged 16 or 17 will be assumed to be able to make decisions for themselves, unless evidence shows that they lack the capacity to do so. However for the purpose of Safeguarding a child is a person under the age of 18 so safeguarding children's procedures always takes precedence. Under the MCA 2005, decisions can be made on behalf of individuals aged 16 and over who lack the capacity to make such decisions for themselves, provided that this is in the person's best interests and does not give rise to a 'deprivation of liberty'. Children and young people (16 and 17) who are unable to make decisions for themselves should still be involved in decisions being made about them.

The MCA (2005) should be considered for any assessment and decision making process when considering cases of abuse. Capacity is decision and time specific. There is a presumption of capacity, if there are concerns about a person's capacity to make relevant decisions a Mental Capacity Act compliant capacity assessment should be completed. Where it is found that the adult lacks capacity then any actions taken, must be in their best interests and in accordance with the Mental Capacity Act 2005 and the associated Code of Practice.

Lack of Capacity

- When a person has been assessed as lacking capacity, interventions can be made in the person's best interests. In urgent situations where the person lacks capacity and there is imminent, serious risk/danger to the person, an emergency application can be made to the Court of Protection.
- It is worth considering that even when a person has capacity but is an Adult at Risk and there is serious risk/danger to the person, the relevant agency could approach the High Court for appropriate legal authority to intervene.

Transitions

The term transition can refer to any change from one provision to another due to age. Transitions between school stages, e.g. from early years to primary, or primary to secondary can be difficult times for disabled children and young people. Some disabled children have specific issues in dealing with change and this needs to be planned for and supported. Moving from one group of professionals and supporters who understand their needs and communication to another may mean a child or young person is more vulnerable, processes such as Education, Health and Care Planning, and the multi agency planning that surrounds and informs them must include consideration of specific needs in relation to transition.

Preparing for Adult Life

The term transition is also specifically applied to young people moving from “children’s services” at 18 to use adult services, most often in terms of moving to adult social care, or adult health services. Ensuring that disabled young people and adults have the best opportunities to be as independent as possible, to be well supported by their communities and social networks and their voice is heard is a key component of safeguarding. Preparing for adulthood does not begin at 17 or 14: as with all children and young people, raising aspirations and expectations for adulthood begins in early life. All practitioners, family and other supporters of disabled children and young people should be encouraged to consider how they contribute in an age appropriate way to that child progressing in terms of the “Preparing for Adulthood Outcomes” as set out in the SEND Reforms: Employment, Independent Living, Friends and Social Networks, and Healthy Living. Safeguarding issues that impact on a 17 year old are unlikely to disappear on their 18th birthday, so where there are already safeguarding issues , forward planning needs to consider how to provide an appropriate adult safeguarding plan.

Social Care

Disabled young people who may be eligible under the Care Act are assessed, signposted and / or receive a support package through the Preparing for Adulthood Team. Referrals to this team can be made via Care Direct. Children's social-workers are encouraged to review a young person around their 17th birthday, so that the young persons' needs are discussed and good longer term plans can be made. Formal referrals if appropriate should be made to the service at least 6 months prior to the persons 18th birthday. The Preparing for Adulthood Team will review, and support plan with a young person up until their 25th birthday, in order to ensure they receive the right input maximise their progress and achieve their short term and longer term aspirations. The team will work with families and other support networks as appropriate. Young people who still require support and provision at 25 will have their social care support reviewed by adult care teams as appropriate. For some young people, moving into adulthood also means a slightly different approach to managing risk, because of the greater emphasis on independence; this work includes consideration of adult safeguarding planning. It is important that information is shared between services at this point.

Health Care

Moving from children's to adult health care systems may have a bigger impact on disabled young people than on others: health services may have been a bigger part of their experience and may include very trusted individuals; disabled children may have been receiving most of their provision through specialist services rather than through general practice.

Children and Adults Health Services have therefore been working together to develop agreed processes to ensure that young people are referred to, and welcomed into, adult services in a timely way, by developing a Standard Operating Procedure for children's services which are part of Bristol Community Health These cover young people whose health conditions include: Chronic physical, mental and emotional health conditions; Complex Health Needs; Palliative Care needs; Learning Disabilities. It also includes Children in Care.

Adult Social Care

Adult social care work with people using a strength based approach and in the first instance will carry out a support conversation to work with an someone to identify their strengths, assets and to identify universal services that they can access for themselves to maximise their independence. This may then lead onto a fuller assessment under the Care Act if it is indicated that a person may need assistance over a short period of time or help to live their lives.

A referral to adult social care (Care Direct) can be made where it appears an adult may need care and support or an adult is at risk of abuse or neglect. When someone over 18 is still receiving children's services (for example in an education setting until the age of 25) and a safeguarding concern is raised, the matter should be dealt with through adult safeguarding arrangements with children's safeguarding and other relevant partners involved as appropriate (the level of need is not relevant and the young adult does not need to have eligible needs for care and support under the Care Act.

A need can relate to a number of tasks and activities including personal care, accessing the community, caring responsibilities and maintaining the home environment. Any referral should be made with the consent of the person concerned unless the person appears to lack capacity to agree to an assessment. The person or someone making contact on their behalf should identify what they believe the needs are for adult care services.

Safeguarding Adults

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. Bristol Safeguarding Multi-Agency Adults Policy sets out how people and organisations work together to prevent and stop both the risks and experience of abuse or neglect for Adults at Risk. At the same time it details how to make sure that the adults wellbeing is promoted whilst having regard to their views, wishes, feelings and beliefs in deciding on any action. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect and outlines the principles of: Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability. These should always be considered when working with a single or Multi-Agency approach to address such concerns. Failure to identify and engage with adults at risk could have serious implications on their health and wellbeing and their family. The duty for agencies to integrate, cooperate and work in partnership, is a legal requirement placed on all Local Authorities and all agencies involved in care such as the NHS, independent and private sector organisations, housing providers and the Police. Cooperation will allow early intervention and this is seen as the best way to prevent, reduce or delay the need for care, support and safeguarding adults at risk.

It is important to follow a person led and outcome focused process where making safeguarding personal is a priority where the adult is involved in a conversation about how best to respond to a safeguarding situation and the risks that enhances choice, involvement, control, quality of life, wellbeing and safety.

Assessment of Need and Risk Management

The Care and Support statutory guidance (updated 9/12/16) says that the assessment '*should not just be seen as a gateway to care and support, but should be a critical intervention in its own right, which can help people to understand their situation and the needs they have, to reduce or delay the onset of greater needs, and to access support when they require it*.'

The guidance goes on to say that '*local authorities must undertake an assessment for any adult who appears to have any level of needs for care and support, regardless of whether or not the local authority thinks the individual has eligible needs.*'

Local Authorities must ensure they use the least restrictive option and comply with the Human Rights Act 1998 (Article 5 Deprivation of Liberty Safeguards DoLS) and Mental Capacity Act 2005.

Section 42 of the Care Act says that the structure of an enquiry should be as follows;

- Plan what assessments are needed and which agencies are responsible for their completion;
- Coordinate and undertake these enquiries and assessments;
- Evaluate the outcomes of these enquiries and assessments;
- Decide what actions are needed;
- Establish if an advocate is required for the Adult.

On receiving a referral the Local Authority Adult Safeguarding Team will consider, on the basis of assessing the risk indicators and in determining a proportionate response, whether to proceed to a Section 42 Enquiry and formal safeguarding procedures.

When the threshold for a Section 42 Enquiry is assessed to have been met, the Local Authority retains the responsibility for overseeing the enquiry and ensuring that any investigation satisfies its duty under Section 42 to decide what action (if any) is necessary to help and protect the adult, and to ensure that such action is taken when necessary.

In cases where there is disagreement over the threshold assessment, this should be discussed by agencies involved. Where disagreement cannot be resolved, agencies are able to use the BSAB Escalation Policy.

Support for Vulnerable witnesses in the Criminal Justice Process

Special Measures were introduced through legislation in the Youth Justice and Criminal Evidence Act 1999 (YJCEA) and include a range of measures to support witnesses to give

their best evidence and to help reduce some of the anxiety when attending court. Measures in place include the use of screens around the witness box, the use of live-link or recorded evidence-in-chief and the use of an intermediary to help witnesses understand the questions they are being asked and to give their answers accurately.

Vulnerable Adult Witnesses (Section16 YJCEA) can have:

- Mental disorder;
- Learning disability, or;
- Physical disability.

These witnesses are only eligible for special measures if the quality of evidence that is given by them is likely to be diminished by reason of the disorder or disability.

Intimidated Witnesses (Section 17 YJCEA): Intimidated witnesses are defined by Section 17 of the Act as those whose quality of evidence is likely to be diminished by reason of fear or distress. In determining whether a witness falls into this category the court takes account of:

- The nature and alleged circumstances of the offence;
- The age of the witness;
- The social and cultural background and ethnic origins of the witness;
- The domestic and employment circumstances of the witness;
- Any religious beliefs or political opinions of the witness;
- Any behaviour towards the witness by the accused or third party.

Also falling into this category are:

- Complainants in cases of sexual assault;
- Witnesses to specified gun and knife offences;
- Victims of and witnesses to domestic violence, racially motivated crime, crime motivated by reasons relating to religion, homophobic crime, gang related violence and repeat victimisation;
- Those who are older and frail;
- The families of homicide victims.

Intermediaries

Before an intermediary can assist with communication they need to conduct one or more assessment meetings with the witness. The following needs to be considered:

- The criminal case is not discussed during assessment;
- The witness's communication needs;
- Building the necessary rapport with the witness and to determine whether they (the intermediary) are the right person to act as an intermediary for that witness. The intermediary should be provided with information that is relevant to their role and

will help them to maximise communication/ understanding (e.g. the specific vocabulary used by the witness and relevant relationships);

- Registered Intermediaries should be used. The use of an unregistered person as an intermediary can only be considered once the options for using a Registered Intermediary have been exhausted;
- When this is the case, an unregistered intermediary has the same responsibility to the court. They must be independent of the case being investigated (i.e. not witnesses or suspects);
- There is a preference for unregistered intermediaries to be professional people rather than family members, friends or associates. In the event that the particular circumstances of the case are such that it appears that only a non-professional person can perform the function of an intermediary, it is important that the witness is assessed by a Registered Intermediary before proceeding, in order to confirm that the role can only be performed by the non-professional.

The services of an intermediary may be obtained by contacting the Specialist Operations Centre of the National Policing Improvement Agency on 0845 000 5463

Appendix1-Referral to Children's Social Care

You have concerns about a child/unborn child (after 12 weeks of pregnancy)

Child Protection concern – take action now.

Go to speak with Safeguarding Lead immediately. If not available, find the deputy or you act.

Agree who will make the referral to First Response (and call the police on 101 if necessary).

Referral is made to First Response/Police, stating that it is a Child Protection concern.

Action is taken by the appropriate agencies

You will need to record on your own system in writing ASAP (within 24 hours). This applies whether or not you make the actual referral.

Your agency continues to participate in Child Protection Strategy or S.47 Enquiries.

Child is in immediate danger – phone 999

All other welfare and safeguarding concerns

Complete internal concern form and pass to Safeguarding Lead

Lead will assess (with discussion with staff and consultation of any safeguarding file held) to agree actions required.

Concern meets threshold for referral to First Response

Multi Agency or Single Agency led interventions/refer direct to other agencies

No further action – will monitor.

Complete web form referral to First Response (copy of referral kept for file). **Parental consent is required**

First Response CONSIDER REFERRAL AND THRESHOLD (may direct to Pathways Decision Team if threshold is unclear or the MASH if additional multi agency information is needed and direct to:

Early Help Team appropriate. – SAF allocated and referrer informed. Your agency participates in Pre-birth assessment, assessment and plan.

Child in Need s17 enquiries. Allocated to Social Care Unit/Disabled Children's Team referrer informed. Your agency participates in assessment and plan.

Decide no further action and inform your agency.

Appendix 2 - Good Practice - Information Sharing, Referrals and Record keeping

Learning form Serious Case and Adult Reviews details that key issues such as information sharing, the quality of referrals and detailed record keeping are areas where organisations need to improve.

Information Sharing

Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding children and adults.

When working with children and young people, it's important to keep in mind two essential factors:

- Timely information sharing is key to safeguarding and promoting the welfare of children. It enables intervention that crucially tackles problems at an early stage
- If a child is at risk or suffering significant harm, the law supports you to share information without consent.

This must be balanced with ensuring that personal information will be treated respectfully and confidentially. Sharing information appropriately is key to putting in place the right support. When making these decisions, the safety and welfare of the child must be the key consideration. For detailed guidance for Children's Services refer to Information Sharing, request for help and disputes.

For Adults at Risk given the duty to cooperate in the Care Act 2014, there are only a limited number of circumstances in which it would be acceptable not to share information pertinent to safeguarding with relevant multi-agency safeguarding partners. These would be where the person involved has the mental capacity to make the decision in question and does not want their information shared, and:

- Their 'vital interests' do not need to be protected
- Nobody else is at risk
- There is no wider public interest
- No serious crime has been or may be committed
- The alleged abuser has no care and support needs
- No staff are implicated
- No coercion or duress is suspected
- The risk is not high enough to warrant a referral to a Multi-Agency Risk Assessment Conference (MARAC)
- No other legal authority has requested the information

For detailed guidance on Information sharing refer to BSAB Multi Agency Guidance on Information Sharing.

If there is continued reluctance from one partner to share information when there is a safeguarding concern or in instances where an alerting organisation thinks that the local authority response is not sufficient, then the matter should be escalated using the relevant Escalation Policy.

Referrals

Any child protection concerns must be referred to First Response for a child or children and Care Direct for an Adult at Risk. If a professional is unhappy with the outcome of the referral or advice given this should always be escalated using the Resolution of Professional Disagreements for Children and Escalation Procedure for Adults. Always discuss concerns with a manager and ensure concerns are recorded.

Consider the following:

- Past, current and future risks
- Consider risks to unborn baby, other children, self, other adults
- Consider pregnancy related issues e.g. risk of untreated illness resulting in
- Poor antenatal care; implications of impulsive behaviour on unborn baby /children
- Consider risk related to lack of insight and compliance
- Child protection concerns
- Other children
- Mental Capacity for Adults

It is vital that the language used for a referral is clear and easy to understand. It is important to remember to use words and description that all professional will understand across the Multi-Agency landscape of services. As much information as possible should be presented so that First Response have a detailed picture to make a decision.

Record Keeping

All records must be written clearly, and in a manner that can be easily understood by others. They must be accessible to everyone who needs to see them. Any records that contain personal information should be kept in secure storage that is only accessible to those who have authorisation to access these records. Case notes should always be written in a way that respects the person's dignity. Records that are no longer needed should be disposed of confidentially, in line with your organisation's policy on this matter.

Good record-keeping is central to effective safeguarding, even if 'safeguarding' is not required and it particularly important when you are assessing a person's capacity to make their own decisions. People benefit from records that promote good communication and high-quality care.

Failing to keep accurate records of decisions you have made and actions you have taken can put people at risk. It also puts the organisation you work for in a difficult position, and risks its reputation.

Decisions and actions that are not taken, as well as ones that are which explain the rationale behind them should be recorded in each case. It must also be made very clear what is factual information and what is opinion.

Supervision

Good quality supervision of staff is fundamental to safe and effective practice when working with children, young people, families and Adults at Risk. It is essential to professional development and supports practitioners to make sound and effective judgements in relation to outcomes for children, families and adults with care and support needs. This in turn enhances decision making.

Supervision provides a supportive learning environment, an opportunity to reflect on practice, assess risks and make decisions. It will support members of staff to be confident in providing services for children and young people, develop integrated working, improve their own performance and learn from practice.

Appendix 3- Local Contacts

Bristol

Findability has Bristol's Local Offer information. It has information on services for children and young people with special educational needs and/or a disability, and their families, in Bristol, from birth to 25 years old.

The Carers Support Centre provides support, information and advice to carers (including parent carers) living in Bristol and South Gloucestershire.

Telephone: 0117 965 2200, Website:www.carerssupportcentre.org.uk

Supportive Parents provides free, confidential and impartial Special Educational Needs and Disability Information, Advice and Support Service (SENDIASS) for parents, children and young people aged up to 25.Telephone: 0117 989 7725 (lines open Mon, Wed and Fri, 10am to 2pm, term time only), Email:support@supportiveparents.org.uk, Website:www.supportiveparents.org.uk

Contact a Family supports families of disabled children whatever their condition or disabilities by offering information, advice and support. They also bring families together so they can support each other.

Telephone: 07920 654 866, Email:sarah.king@cafamily.org.uk, Website:www.cafamily.org.uk

Cerebra can support families with children affected by a neurological condition aged under 17 years (for example; neuro-genetic conditions, Cerebral Palsy, Epilepsy, Developmental Delay, Autism, ADHD, Learning Difficulties).

Telephone: 0300 600 2930 or 07771 353 739, Email:KathF@cerebra.org.uk, Website:www.cerebra.org.uk

Sense supports children, young people and adults with sensory impairment, and their families. The people we support are Deafblind, or sometimes have single sensory impairment with additional needs and/or Multi Sensory Impairment.

Telephone: 0117 967 0008 or 0797 657 0008, Email:Helen.Potter@sense.org.uk, Website:www.sense.org.uk

Scope offers 'Face 2 Face Online Befriending Service', an email and telephone service which offers emotional support to parents who don't have a local group or prefer email and/or telephone support. All the befrienders are parent carers.

Telephone: 01454 632340, Email:Juliet.blackburn@scope.org.uk, Website:www.scope.org.uk

The Family Centre (Deaf Children) supports families with a deaf child or a deaf parent. Contact us for information and to find out about our activities which includes – family sessions, a kids club, a youth club, family sign language tuition.

Telephone: 0117 330 7575, Text: 07919 575247, Email:office@fcdc.org.uk, Website:www.fcdc.org.uk

KIDS offer free, independent and impartial information and support to parents and young people around Education, Health and Care Plans (EHCP's) and a sexuality and relationships group for young disabled people.

Telephone: 0117 9476111, Email:IS.SouthWest@kids.org.uk, Website:www.kids.org.uk