Multi-agency Thresholds Guidance

We are working together to keep children and young people safe in Cumbria.

September 2016
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1 Introduction

1.1 What is the purpose of the guidance?
The Local Safeguarding Children Board commissioned the review of this guidance in order to support all professionals working with children and young people so that everyone is clear:

- that an early help assessment is, in all but urgent cases, 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;
- a common language is used;
- about regulation and good practice;
- about individual responsibility when working with children, young people and families;
- about the responsibility of different agencies; and
- about the tools in place to support professionals in their role.

1.2 How has the guidance been developed?
The guidance has been written by a wide range of professionals who have been involved in shaping the approach and are actively involved in delivering it. Representatives from Health agencies, Police, Third Sector Organisations, Children’s Centres, Schools and Cumbria County Council Children’s Services1 have provided advice and challenge to the developing guidance and have contributed to the consultation process.

1.3 What does the guidance include?
The guidance describes the overarching approach taken in Cumbria to supporting young people and children (pre-birth up to 18 years) and their families and then explains the different elements of the approach in more detail.

This multi-agency guidance seeks to:

- describe levels of vulnerability and the appropriate response at differing levels;
- set out the principles that underpin the way we will work with children, young people and families;
- make clear the thresholds for action/intervention and provide case studies that give real life examples of this;
- provide a description of the Cumbria Safeguarding Hub and how this works in supporting a multi-agency approach to working with children, young people and families when it is appropriate to use it; and
- provide the necessary information to ensure that those children and young people identified as having additional needs receive timely intervention and have access to services to address these.

1.4 How should the guidance be used?
The guidance is a reference tool for professionals. It provides an overview of the approach and key aspects and therefore should be read alongside other relevant shared policies, procedures and guidance which are signposted in this document or those from your own organisation.

You should apply your own professional judgement when using the guidance as the lists and scenarios included here are not exhaustive.

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1 Throughout this document where we are referring to Cumbria County Council Children’s Services, this will read as Children’s Services. When we are referring to a collective of organisations involved this will read as Children’s Workforce.
1.5 Expectations

It is the expectation of member organisations of the Children’s Trust Board and Local Safeguarding Children Board that all professionals working with children, young people and families will work within this guidance and pay full regard to the more detailed associated policies and procedures in place. All organisations should ensure managers and staff have access to support when working with children and their families.

1.6 Where do I go for more advice and guidance?

All professionals work within their own agency’s policies and procedures and all agencies share the LSCB Safeguarding policies and procedures. The multi-agency Cumbria Safeguarding Hub (0333 240 1727) is the first point of contact where concerns meet the threshold. The Cumbria Safeguarding Hub will make a decision regarding the most appropriate course of action. The Screening Team will provide support, consultation and advice if the concern does meet the required threshold.
2 The Wedge

<table>
<thead>
<tr>
<th>Level of need</th>
<th>Level of support to meet need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal services</td>
<td>Universal services are available to all children and young people. The most easily identifiable universal services that children and families will access are primary health education.</td>
</tr>
<tr>
<td>Single agency</td>
<td>This is the first level of intervention after universal services. It is a single setting/single agency response based on a dialogue with the child/family. The needs of a child or young person can be met by additional support from one agency.</td>
</tr>
<tr>
<td>Early help</td>
<td>A professional seeking advice and input from other agencies in order to meet a child’s unmet needs. Discussion would first take place with the child/family to identify needs and agree outcomes and actions. Early Help Assessment (EHA) and plan of work would be initiated at this stage. Intervention is aimed at preventing escalation to statutory intervention. Evidence of an Early Help Assessment and intervention will help support a referral for statutory intervention if required at a later date.</td>
</tr>
<tr>
<td>Statutory Intervention</td>
<td>The highest level of multi-agency intervention. Statutory intervention takes place in response to complex needs, involving multi-agency specialists where the consequences of non-intervention could lead to serious harm. These children may be at risk of becoming looked after or subject to a Child Protection plan. This level also includes children with severe disabilities or complex learning difficulties. Contact with the County Safeguarding Hub is appropriate.</td>
</tr>
</tbody>
</table>

Each child or young person has different needs and will need different support in order to ensure their needs are met and they meet their potential in life and thrive. The Wedge model on this page describes three different levels of additional requirements and support that children, young people and families within Cumbria might experience. Each separate level in the Wedge is described in more detail in the guidance to assist professionals in identifying and assessing where a child or young person lies on this spectrum and understanding the subsequent actions expected of them at each level in order to ensure that the child’s needs are met.

All children and young people have access to a range of universal services provided in their communities. These services include schools, early years settings, health, housing, youth services, leisure facilities and services provided by voluntary organisations.
However, some children have greater needs and may require additional support or support from more than one agency. Where this is necessary, in Cumbria our expectation is that there is a focus on early help and prevention services in order to ensure that children, young people and their families receive the most appropriate support to meet their needs at the earliest opportunity. In summary, the three levels of need are:

• single agency response to meet need;
• early help: focussed plan led by team around the family statutory intervention;
• statutory support

Only a small proportion of children and young people in the county will need statutory intervention.
3 Children and Young People in Cumbria

3.1 Our vision and aspirations

Our vision is: ‘We are working together to keep children and young people safe in Cumbria’.

Approximately 99,100 children and young people under the age of 18 years live in Cumbria. This is 20% of the total population in the area. (Source: Mid-2014 Population Estimates, ONS)

Approximately 13.8% of the local authority’s children (aged 0-19 years) are living in poverty (Source: HMRC).

Children and young people from minority ethnic groups account for 2% of all children living in the area, compared with 22% in the country as a whole. 4.6% of statutory school aged pupils in Cumbria are from Non-White British ethnic groups (Black and Minority Ethnic groups), below the national average of 28.6% (Source: January 2016 School Census).

Children and young people live in communities which range from isolated rural settlements and farms to market towns and larger urban conurbations. Of the county’s population, 53.6% live in rural areas, compared with 17.6% of the population in England and Wales. (Source: Office for National Statistics, 2011).

Cumbria has been developing an effective safeguarding board with strong partnership working arrangements and this will continue to be built on and strengthened. Through the Board structure the LSCB provides the strategic and operational direction of safeguarding and continuous monitoring of performance in Cumbria. The Board produces a three-year Business Plan and an Annual Report. cumbrialscb.com/about/

4 Single Agency Response

The single agency response is based on a dialogue with a child/family. The role of professionals working with this group of children is to promote a healthy lifestyle, increase their achievement and resilience thereby maximising their life chances. It is also about empowering families. Usually, these children will make good overall progress in all areas of their development by accessing universal services. Occasionally these children will develop some additional needs which can be addressed by your agency alone e.g. struggling to achieve educational targets, regular advice to support a single health issue, short term friendship/relationship issues. This level of professional intervention will usually be time limited and will be delivered within a single agency setting.

A key message from Professor Eileen Munro’s recent review of child protection is of the vital role that professionals working in universal services have in the provision of early help.

“...it is a shared responsibility for all those working with children and young people and families in local area...” (Munro, 2011).

This principle is a key foundation of the Cumbria LSCB partnership approach.
**Single Agency Response:**
A single agency response based on a dialogue with the child/family

**Examples of presenting characteristics of areas of need**

**Child’s developmental needs**
This will include physical and emotional health, learning and behavioural development, family and social relationships.

- Struggling to achieve expected targets at end of key stages.
- No barriers to learning, but may lack focus and or need additional curricular support.
- Good all round physical and mental health, achieving developmental milestones, but may need regular advice or support regarding a single health issue.
- Child feeling sad because of a bereavement or loss e.g. death of extended family member/friend, separation of parents, chronic illness in family.
- Behavioural needs e.g. young person who usually respects school and parental boundaries starts being late for school and staying out after home curfew.
- Child at risk of bullying or being bullied.
- Generally good attachments with peers and family however may experience friendship or relationship issues that may need to be discussed to provide solutions.

**Parenting**
This will include basic care, guidance and boundaries, emotional warmth and stability whilst ensuring safety.

- Basic issues with parental care.
- Contact disputes between parents/carers.

**Family and environmental**
This will include family history and relationships, wider family, housing and finance and resources available locally.

- Benefits/housing issues.
- Financial difficulties which mean child is living on the edge of poverty.

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**Assessment**
No EHA required or in place at this level of need, individual professionals will undertake their assessment according to the presenting need.

**Response**
Family and single agency have dialogue about areas for concern.

**Key Services likely to be involved:**

- Children’s Centres
- Early Years Services
- GP
- Health visiting services
- Midwife
- Careers Information, Advice and Guidance
- Police
- School nurse
- Schools
- Targeted Youth Support
- Voluntary and community sector
5 Early Help

Early Help is the response made when a professional identifies needs with a child/family and works with another agency or agencies to meet those needs. Early help means ‘providing support as soon as the problem emerges, at any point in the child’s life from the foundation years through to the teenage years.’ Working Together (2015).

At this level of need an Early Help Assessment (EHA) should be completed with the child and family to identify needs and agreed desired outcomes. A good assessment of needs and the establishment of achievable and measurable outcomes is an essential element of effective early help. Any worker who supports children and families should initiate this process when a need for a multi-agency response is identified.

An Early Help Assessment can be carried out with any child or young person from pre-birth up to age 18 (up to the age of 25 if the young person has a learning difficulty or disability.

Completion of an Early Help Assessment is part of a continuing process to assess and meet the needs of children and young people. It is not a one-off application form for additional support.

The completion of an EHA would trigger a response from different agencies. A date should be set for a Team Around the Family (TAF) meeting, in order to identify a co-ordinator, agree the plan and which agency would work to achieve each of the agreed outcomes.

When a professional or group of professionals is concerned about how to deliver the plan or are unable to identify an appropriate co-ordinator the case should be taken to the District Early Help Panel.

EHAs should be registered with the Early Help Team. Send your completed registration forms to early.help@cumbria.gov.uk

Cumbria’s Early Help Team is available to support professionals completing EHAs. More information about the team and early help can be found at: http://cumbrialscb.com/professionals/earlyhelp/default.asp

The LSCB website also includes the Early Help Directory which provides information about agencies and organisations who can bring expertise and resource to Team Around the Family. Further information is also available on the Cumbria Local Offer site: http://localoffer.cumbria.gov.uk/kb5/cumbria/fsd/home.page

If the child or young person no longer being supported by the Early Help Assessment process, there needs are met or they can be met by a single agency, then the assessment needs to be closed. Use the Early Help Closure of Assessment Form you can find that on the LSCB website here cumbrialscb.com/professionals/earlyhelp/default.asp
Early Help
A professional seeking advice and input from other agencies in order to meet a child’s needs. Discussion would first take place with the child/family to identify needs and agree outcomes and actions. An Early Help Assessment (EHA) would be initiated at this stage.

Examples of presenting characteristics of areas of need

<table>
<thead>
<tr>
<th>Child’s developmental needs</th>
<th>Parents and carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>This will include physical and emotional health, learning and behavioural development, family and social relationships.</td>
<td>This will include basic care, guidance and boundaries, emotional warmth and stability whilst ensuring safety.</td>
</tr>
<tr>
<td>• Special Educational need identified in school.</td>
<td>• Teenage parent(s).</td>
</tr>
<tr>
<td>• Identified language and communication difficulties.</td>
<td>• Parents/carers have relationship difficulties which may affect the child.</td>
</tr>
<tr>
<td>• Occasional truanting / unexplained school absences.</td>
<td>• Adoption support advice.</td>
</tr>
<tr>
<td>• Few or no qualifications.</td>
<td>• Parents/carers request advice to manage their child.</td>
</tr>
<tr>
<td>• Not in education, employment or training (NEET).</td>
<td>• Parents engaging with agencies but have their own needs.</td>
</tr>
<tr>
<td>• Short-term exclusions.</td>
<td>• Loss of a significant adult.</td>
</tr>
<tr>
<td>• Not achieving some key milestones.</td>
<td>• Inconsistent care e.g. inappropriate child care arrangements or young inexperienced parent.</td>
</tr>
<tr>
<td>• Slow in reaching developments milestones.</td>
<td>• Under or over engagement with services.</td>
</tr>
<tr>
<td>• Missed immunisations and appointments.</td>
<td>• Historic domestic violence</td>
</tr>
<tr>
<td>• Health concerns–diet, hygiene, alcohol (but not immediately hazardous).</td>
<td>• A pattern of inconsistent male figures appearing in the family.</td>
</tr>
<tr>
<td>• Experimenting in substance abuse.</td>
<td>• Mum suffering from post-natal depression.</td>
</tr>
<tr>
<td>• Starting to have sex (under 16 years).</td>
<td>• Different carers.</td>
</tr>
<tr>
<td>• Low level mental health or emotional issues requiring intervention such as continued signs of distress or anxiety; expressing thoughts and feelings.</td>
<td>• Child spends much of their time alone.</td>
</tr>
<tr>
<td>• Coming to the attention of the police through low level offending.</td>
<td>• Carers unable to set boundaries and have an inconsistent approach to parenting.</td>
</tr>
<tr>
<td>• Inappropriate sexual behaviour.</td>
<td>• Substance/alcohol misuse by carers in their home.</td>
</tr>
<tr>
<td>• Low level substance abuse (current or historical).</td>
<td>• Young person at risk of becoming homeless.</td>
</tr>
<tr>
<td>• Lack of age appropriate and independent living skills that increase vulnerability to social exclusion.</td>
<td>• Overcrowding.</td>
</tr>
<tr>
<td>• Experiencing bullying or has been bullied.</td>
<td>• Child is carer for younger siblings.</td>
</tr>
<tr>
<td>• Poor self esteem/insecurities around identity.</td>
<td>• Child is a Young Carer.</td>
</tr>
<tr>
<td>• Struggles to make and keep friendships.</td>
<td></td>
</tr>
<tr>
<td>• Undertaking occasional caring responsibilities.</td>
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<tr>
<td>• Low parental aspirations.</td>
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<table>
<thead>
<tr>
<th>Family and environmental</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This will include family history and relationships, wider family, housing and finance and resources available locally.</td>
<td></td>
</tr>
<tr>
<td>• Benefits/housing issues with a complicating factor.</td>
<td>• Young person at risk of becoming homeless.</td>
</tr>
<tr>
<td>• Family affected by low income or unemployment.</td>
<td>• Overcrowding.</td>
</tr>
<tr>
<td>• Child affected by poverty.</td>
<td>• Child is carer for younger siblings.</td>
</tr>
<tr>
<td>• Children affected by difficult family relationships or bullying.</td>
<td>• Child is a Young Carer.</td>
</tr>
</tbody>
</table>
Early Help continued

Assessment
An Early Help Assessment (EHA) should be completed with the child/young person and family to identify strengths and needs and to identify support. A Team around the Family (TAF) and a Co-ordinator will be identified and put in place, and a needs led, outcome focused plan will be developed. This will be reviewed regularly with the family to ensure the plan is effective and actions are being taken by all to support change.

Response
Additional agency involvement agreeing actions with the child/family.

Key Services likely to be involved

- Access and Inclusion team.
- Careers Information, Advice and Guidance.
- Child and Family Worker.
- Children’s Centres.
- Community Support Officers.
- Drug and alcohol services.
- Early Years Services.
- Educational Psychologist.
- GP.
- Health visitor.
- Housing Providers.
- Learning Mentors.
- Midwife.
- Specialist Teachers.
- Police.
- School Nurse.
- Schools.
- Targeted Youth Support.
- Voluntary and Community Sector.
- Youth Offending Service.
- Young carers.
6 Statutory Intervention

Statutory intervention takes place in response to complex need involving multi-agency specialists where the consequence of non-intervention could lead to risk of serious harm. This level also includes children with severe disabilities and learning difficulties. A statutory Child and Family assessment should be undertaken in accordance with ‘Working Together’ (2015).

The key factor in determining if a child or young person requires statutory intervention is the ‘risk of serious harm’ and any decision to move to a request for statutory intervention or undertaking a statutory child and family assessment should be supported by a clear analysis of the risks (see Appendix 2).

Children with this level of need include:

- All children and young people determined by the Cumbria Safeguarding Hub as being at risk of significant harm and all children who are subject of a Child Protection Plan;
- All children and young people who are looked after by the local authority;
- All children and young people where the initial information provided to the Cumbria Safeguarding Hub indicates that a significant level of service is required for a child or young person with a disability; and
- Children in Need as identified in Section 17 of the Children Act 1989, examples including children on the edge of becoming ‘looked after’ by the Local Authority, and/or young people in custody or at risk of custody.

The outcome of a statutory child and family assessment maybe:

- The risks are deemed to be such that the child can be supported at the early help level.
- The child is supported through a child in need plan.
- The child becomes subject to a child protection plan.
- The child may be considered to be at such risk that they should become looked after.

Whatever the outcome of the statutory assessment the child and in most cases the family will continue to receive support from a multi-agency team.
**Statutory Intervention**
Statutory Intervention takes place in response to complex need involving multi-agency specialists where the consequence of non-intervention could lead to risk of serious harm. These children could become looked after. This level also includes children with severe disabilities and learning difficulties.

**Examples of presenting characteristics of areas of need**

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</tr>
<tr>
<td>• Chronic non-attendance at school or other educational provision.</td>
<td>• Significant parental discord and recent episodes of domestic violence in the home.</td>
</tr>
<tr>
<td>• Permanently excluded from school with a history of previous exclusions.</td>
<td>• Home environment or hygiene places the child at risk of harm.</td>
</tr>
<tr>
<td>• Significant developmental delay.</td>
<td>• Parents have been unable to care for previous children.</td>
</tr>
<tr>
<td>• Non-organic failure to thrive.</td>
<td>• Lack of supervision resulting in significant harm to the children.</td>
</tr>
<tr>
<td>• Fabricated induced illness.</td>
<td>• Child experiencing acute emotional rejection by parents.</td>
</tr>
<tr>
<td>• Physical injury which may be from one single serious injury or a pattern of sustained injuries.</td>
<td>• Refusing support/intervention from agencies.</td>
</tr>
<tr>
<td>• Chronic neglect which presents an imminent danger to the child.</td>
<td>• Instability and violence in the home.</td>
</tr>
<tr>
<td>• Early teenage pregnancy.</td>
<td>• Adoption breakdown.</td>
</tr>
<tr>
<td>• Sexual activity under 13 years.</td>
<td>• Parent is refusing medical intervention which are agreed by medical professionals are in the best interest of the child.</td>
</tr>
<tr>
<td>• Child with a disability under definition of Children Act requiring immediate intervention.</td>
<td>• Risk of sexual exploitation/trafficking.</td>
</tr>
<tr>
<td>• Serious self harm including eating disorders.</td>
<td>• Parents abandon child.</td>
</tr>
<tr>
<td>• Serious misusing substances in a manner that is seriously impacting on their health.</td>
<td>• Persistently deprives child of stimulation through care e.g. shuts child in a room/ leaves child alone in cot for long periods.</td>
</tr>
<tr>
<td>• Risk taking behaviour which places self and others in danger.</td>
<td>• Parent gives/allows child to use illicit substances.</td>
</tr>
<tr>
<td>• Severe attachment problems and/ or severe emotional developmental delay.</td>
<td></td>
</tr>
<tr>
<td>• Runs away or is frequently missing for long periods from home.</td>
<td></td>
</tr>
<tr>
<td>• At risk of or have caused significant physical or sexual harm to another child/ young person.</td>
<td></td>
</tr>
<tr>
<td>• Unaccompanied asylum seeker.</td>
<td></td>
</tr>
<tr>
<td>• Repeated criminal activity/coming to the attention of police and YOT.</td>
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</tr>
</tbody>
</table>

**Family and environmental**
This will include family history and relationships, wider family, housing and finance and resources available locally.

<p>| |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>• Parents are in prison and there are no other family members or friends to care for the children.</td>
</tr>
<tr>
<td>• Contact with adult who poses an actual or potential risk to children.</td>
</tr>
<tr>
<td>• Parents are deceased and there are no other family or friends who can care for the children.</td>
</tr>
<tr>
<td>• Privately fostered.</td>
</tr>
<tr>
<td>• Homelessness.</td>
</tr>
<tr>
<td>• Financial difficulties which are so severe that child’s basic needs cannot be met.</td>
</tr>
</tbody>
</table>

**Assessment**
A statutory Child and Family assessment should be undertaken in accordance with ‘Working Together’ (2015).
### Key Services likely to be involved

- Access and Inclusion team
- Careers Information, Advice and Guidance
- Child and Family Worker
- Child and Adolescent Mental Health Services (CAHMS)
- Children’s Centres
- Community Support Officers
- Cumbria Safeguarding Hub
- Drug and alcohol services
- Early Years Services
- Educational Psychologist
- Family Assessment and Support Team (Children & Families Services)
- Family support from third sector agencies or other commissioned providers
- GP
- Health visitor
- Housing providers
- Learning Mentors
- Midwife
- Specialist Teachers
- Police
- Pupil Referral Unit
- SEND Team (Children & Families Services)
- School nurse
- Schools
- Short Breaks Providers for disabled children (Children & Families Services)
- Special Educational Needs Services
- Specialist Health Services
- Specialist Teachers
- Targeted Drug and Alcohol services
- Targeted Youth Support
- Teenage Pregnancy Services
- Voluntary and Community Sector
- Youth Offending Service
- Young carers.
7 Step-Up and Step-Down

The needs of the child will assist agencies in ensuring that the child receives the appropriate service from the appropriate people at the appropriate time. Plans for support by agencies will be developed based on the child’s identified needs, the seriousness of these and the strengths of the child and his/her family. Identified outcomes will be specified and a plan agreed. The plan will set out who will do what, how often, how we will know the outcomes have been achieved and what can happen if they are not. The approach to writing a plan is the same at all levels of the threshold: the title of the plan will indicate the level e.g. Hospital discharge plan, EHA, Child in Need Plan, Child Protection Plan, Children Looked After Plan and Leaving Care Plan. It is not necessary or relevant for all children to have all these plans. It maybe that during the period a child requires support, they may already have a plan. Throughout this guidance we have considered the levels of need of a child.

Where support is successful in addressing these needs and reducing the levels of concern/risk the professionals involved can discuss with the child/family reducing the level of support. This is referred to as Step Down.
Case open to Children’s Services to close.

The decision to Step Down to Early Help Assessment will be discussed at the penultimate meeting of CIN/CP/CWD led by Children’s Services.

Recommendation to ‘Step Down’ agreed at this meeting. Family made aware of the Early Help Assessment and consent to Step Down. Parent and Child information leaflets supplied. Family consent to ‘Step Down’ to Early Help Assessment.

CIN/CWD
The final CIN/CWD meeting will become the first TAF of the “Step Down” to Early Help. This meeting will be chaired by the social worker. The TAF co-ordinator is confirmed. If the identified co-ordinator is not present social worker to arrange a ‘handover’ meeting with identified co-ordinator.

Social worker to register the Early Help Assessment using the Early Help Registration Form. Registration forms to be emailed to early.help@cumbria.gov.uk. Social Worker to close case within Children’s Services.

Unmet needs that remain from the CIN/CP/CWD plan to be transferred by the social worker to the Early Help Action Plan. There is no need for the identified co-ordinator to complete the full Early Help Assessment.

The identified co-ordinator arranges the following Team Around the Family meetings.

Team Around the Family meetings continue.

Needs met or can be met by a single agency complete Early Help Assessment Closure Form send to early.help@cumbria.gov.uk
Appendix 1
Contacting Cumbria Safeguarding Hub
Does this child need an immediate child protection response if so continue to report your concern to the Hub. **IF NOT:**

- Could this child be helped by an Early Help Plan?
- Can I identify other professionals to contribute to an Early Help Plan?
- If so please seek support from your own service advisor or the Early Help Team to work with the family to prevent escalation of need.

Unless your contact requires an immediate child protection response the Hub will ask you about the recent Early Help Plan and Team around the child meetings and will make a decision about the level of vulnerability. This will be either:

- **Child Protection Response**
  - Will process to District Social Work Team within 2 hours
- **Requires further investigation**
  - Process to the MASH
  - Referrer is recommended to undertake an Early Help plan, with support from the Early Help team if required.
- **Needs Early Help Plan**
  - Needs no further action, or provision of Professional Advice
  - Referrer is recommended to undertake an Early Help plan, with support from the Early Help team if required.
- **CP Response required**
  - Needs no further action, or provision of Professional Advice
- **SW Child in Need response required**
  - Early Help response required
  - Needs no further action, or provision of Professional Advice

We trust you will be part of an agreed outcome in line with the Cumbria Threshold Guidance. Where decision have been made following the Hub episode we will provide feedback on the destination of your contact via email or letter. However you are also responsible for knowing what has happened to your concern, so if you have not had any feedback within 72hrs you MUST contact the Hub and ask.
Appendix 2
Risk
One of the challenges for professionals in assessing need, particularly at the targeted and intensive levels, is in making decisions about when a level of need may escalate (or has already escalated) to the point at which they judge there to be significant risk to the wellbeing of that child, young person or other person. Professor Eileen Munro recommends that professionals adopt “a system that is risk sensible” (2008) To do this effectively, need has to be assessed alongside protective factors and resilience, in terms of both the child/young person's development and in terms of their family and environmental context.

**Scenario:** Mum has post-natal depression and has not left her home for several weeks. She is struggling to care for her four month old baby and five year old daughter. The needs of both the baby and child will look very different in the following situations, and trigger different levels of service response accordingly:

- Mum is a single parent in an area with no family or friend networks. She is breast feeding but feels too depressed to leave the house. As a result, she is unable to get shopping and therefore cannot feed herself or her older child.
- Mum is a single parent and has extended family living within the local community who have rallied round and regularly visit and help with shopping, cooking and child care.

Risk can be described as the possible impact on a child or young person's well-being, connected to issues or situations in their lives which are known as ‘risk factors’. There are some well identified risk factors including: Health and Development: temperament; levels of emotional maturity; gender; IQ; school transition stages; emotional resilience; language and communication; physical health. Parenting and family: bereavement; poor supervision; high criticism/low warmth relationships; parental criminality; parental discord, domestic violence. Environment: inadequate housing; poverty; lack of family and social networks. Risk is cumulative - one risk factor on its own may mean professionals need not be unduly concerned, whereas in relative terms, the presence of two or more risk factors particularly where they exist across the domains of development, family and environment increases the impact on wellbeing considerably. The Wedge (see page 9) has been specifically designed with this in mind. Identifying the areas of strength and need will support professionals to construct an overall 'map' which will support professional decision making.

Assessment of risk is also informed by the level of resilience and protective factors present in a child or young person and their support systems. Research by Barnardos (2004) states resilience as being: “…a universal capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity”. The box below identifies basic principles of resilience and practical applications to assist the professional in assessing a child’s needs.


- Risk factors are cumulative – the presence of one increases the likelihood that more will emerge.
- Transition points in children’s lives can be both threats and opportunities.
- Where the cumulative chain of adversities can be broken, most children are able to recover from even severe adversities in early life;
- Managed exposure to risk is necessary if children are to learn coping mechanisms.
- Key factors promoting resilience in children are support from family and/or peers, good educational experiences, a sense of self-efficacy and opportunities to contribute to family or community life by taking valued social roles.
- Acute episodes of stress are less likely than adversities to have long-term effects on children's development.
- In promoting resilience, the goal is effective adult adjustment rather than eliminating the legacy of all childhood difficulties.
- Children and young people who have experienced difficulties report often being helped by non-professional supporters (friends and family), rather than professionals.
Appendix 3
Assessment Tools

The Risk and Resilience Model and Matrix 23-26
The Salford Graded Care Profile 28-57
LSCB Scaling tool - March 2015 58-59
Identifying Neglect –
The Risk and Resilience Model and Matrix

What is resilience?

Resilience is a key factor in protecting and promoting good mental health. It is the quality of being able to deal with the ups and downs of life, and is based on self-esteem. Fonagy defines resilience as “normal development under difficult circumstances.”


*Rather than rescuing so-called ‘survivors’ from ‘dysfunctional families’, this practice approach engages distressed families with respect and compassion for their struggles, affirms their reparative potential, and seeks to bring out their best qualities.”*

*(Walsh (2008) Pg 31, Barlow & Scott, op cit,)*

The Risk and Resilience Model has been developed to support practitioners to understand the interaction between the factors and gain some sense of the risks of impairment to the child’s health and development and plan interventions.

The Risk and Resilience Model by Daniel and Wassell


Resilience looks different for each age and stage of development although some factors are common no matter what age. Even though there are common and known factors for children, what is not known is how each area will interplay with the other to affect the individual child.

Resilience and vulnerability are internal characteristics which are shaped by the child’s own genetic and nature / nurture factors, along with their own character and how they perceive and respond to situations.

**Internal characteristics**

Vulnerability  >  Resilience

Assessing resilience is important because it is associated with better long-term outcomes for children, therefore it can be used to guide planning for children whose lives have been disrupted by abuse of neglect and who might require to be looked after away from home (Gilligan, 1997).

It cannot be looked at in isolation, as the extrinsic factors of protective and adverse environments will interact with the internal model of the child.

**External characteristics**

Adversity  >  Protective environment
Adversity and protective factors come from outside the child, in the behaviour of adults, the resources available in
the community and the ability of the child and family to make use of these.

• Combined, these areas create a balanced picture of the child, their family and the environment they live in, and
how they interact with each other.

• It is important to remember that a child is not a passive receptacle. Interactions between themselves and other
people and the environment in which they live will shape their experiences and development. How they respond
to adversity will depend upon their own resilience and vulnerability.

• It is in observing and analysing the interactive factors of resilience, vulnerability, adversity and protective factors
that we start to understand how best to begin to meet the child’s needs.

**Understanding risk and resilience factors**

There are a number of common resilience and vulnerability factors identified for different age groups. Once these
factors are identified within the individual child the question has to be asked:

**What is nurturing or hindering the factors that influence the child’s life?**

Each identified factor should be examined against this question.
We are working together to keep children and young people safe in Cumbria.

**Variables**
- Timing & age
- Multiple adversities
- Cumulative protective factors
- Pathways
- Turning points
- A sense of belonging

**Resilience**
- Good attachment
- Good self-esteem
- Sociability
- High IQ
- Flexible temperament
- Problem solving skills
- Positive parenting
- Attractive

**Intervention**
- Strengthen protective factors and resilience
- Reduce problems and address vulnerabilities
- Achieve initial small improvements

**Resilient Child**
- High adversity

**Resilient Child Protective Environment**

**Adversity**
- Life events/crisis
- Illness loss bereavement
- Separation/family breakdown
- Domestic violence
- Asylum seeking status
- Serious parental difficulties e.g.: drug abuse/alcohol misuse
- Parental mental illness

**Vulnerable child**
- High Adversity

**Protective Factors**
- Good school experience
- One supportive adult
- Special help with behavioural problems
- Community networks
- Leisure activities
- Talents and interests

**Vulnerability**
- Poor attachment
- Minority status
- Young age
- Disability
- History of abuse
- Innate characteristics in child/family that threaten/challenge development
- A loner/isolation
- Institutional care
- Early childhood trauma
- Communication differences
- Inconsistent/neglectful care

Some common factors for child vulnerability

Child vulnerability is the first conclusion you make when completing a risk assessment. A judgment about child vulnerability is based on the capacity for self-protection. Self-protection refers to being able to demonstrate behaviour that results in defending oneself against threats to safety and results in successfully meeting one’s own basic (safety) needs:

- **Age** – children from birth to six are always vulnerable.

- **Physical Disability** – Regardless of age, children who are unable to remove themselves from danger and are highly dependent on others are more vulnerable.

- **Mental disability** – children who are cognitively limited are vulnerable in a number of areas; recognising danger, knowing who can be trusted, meeting their basic needs, and seeking protection.

- **Perceptions of provocative behaviour** – a child’s emotional, mental health, behavioural problem can be such that they irritate and provoke others to act out toward them or to totally avoid them.

- **Powerless** – regardless of age, intellect, and physical capacity, children who are highly dependent and susceptible to others are vulnerable. These children typically are so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them.

- **Defenceless** – regardless of age, a child who is unable to defend him/herself against aggression is vulnerable. This can include children who are oblivious to danger. Remember that self-protection involves accurate reality perception particularly related to dangerous people or situations.

- Children who are frail or lack mobility are more defenceless.

- **Non-assertive** – regardless of age, a child who is so passive or withdrawn to not make his or her basic needs known is vulnerable. A child who cannot or will not seek help and protection from others is vulnerable.

- **Illness** – regardless of age, some children have continuing or acute medical problems and needs that make them vulnerable.

Common protective factors for resilience building

To achieve their maximum potential, children and young people will be protected by having all the things we know they need:

- good education;
- love and sense of belonging;
- decent standard of living;
- great parenting;
- intelligence;
- good looks; and
- opportunities to contribute.
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The Salford Graded Care Profile

Adapted from The Graded Care Profile designed by Dr Leon Polnay and Dr O P Srivastava, Bedfordshire and Luton Community NHS Trust and Luton Borough Council.

Available at: www.salford.gov.uk/sscb

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Introduction

The Graded Care Profile (GCP) was developed as a practical tool to give an objective measure of the care of children across all areas of need by Drs. Polnay and Srivastava. The profile was developed to provide an indication of care on a graded scale. It is important from the point of view of objectivity because the ill effect of bad care in one area may be offset by good care in another area. It has been adapted to meet the needs of Salford, but the quality of the original version is acknowledged.

It is a descriptive scale. The grades indicate quality of care and are recorded using the same 1 – 5 scale in all areas. Instead of giving a diagnosis of neglect it defines the care showing both strengths and weaknesses as the case may be. It provides a unique reference point. Changes after intervention can demonstrably be monitored in both positive and negative directions.

It can be used to improve understanding about the level of concern and to target areas for work as it highlights areas of greater risk of poorer outcomes. It should be used in all cases where neglect is identified as an issue. The Profile can be used with the family by individual workers, or groups of workers, to inform Family Action meetings and child protection Core Group meetings.


There is also a link [http://www.salford.gov.uk/risk-and-protectivefactors-triangle.pdf](http://www.salford.gov.uk/risk-and-protectivefactors-triangle.pdf) to a Risk and Protective Factors tool, which can help identify children at risk of poorer outcomes.

Finally it should be remembered that it provides a measure of care as it is actually delivered irrespective of other interacting factors. In some situations where conduct and personality of one of the parents is of grave concern, a good care profile on its own should not be used to dismiss that fact. At present it brings the issue of care to the fore for consideration in the context of overall assessment.
Grades

In this scale there are five grades based on levels of commitment to care. Parallel with the level of commitment is the degree to which a child’s needs are met and which also can be observed. The basis of separation of different grades is outlined in Table 1 below.

Table 1.

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
<th>Grade 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All child’s needs met</td>
<td>Essential needs fully met</td>
<td>Some essential needs unmet</td>
<td>Most essential needs unmet</td>
<td>Essential needs entirely unmet/hostile</td>
</tr>
<tr>
<td>2</td>
<td>Child first</td>
<td>Child first, most of the time.</td>
<td>Child/carer at par</td>
<td>Child second</td>
</tr>
<tr>
<td>3</td>
<td>Best</td>
<td>Adequate</td>
<td>Borderline</td>
<td>Poor</td>
</tr>
</tbody>
</table>

1. = level of care; 2 = commitment to care; 3 = quality of care

These grades are then applied to each of the four areas of need based on Maslow’s hierarchy of needs – physiological, safety, love and belongingness and esteem. This model was adopted not so much for its hierarchical nature but for its comprehensiveness. Each area is broken down into sub-areas, and some sub-areas to items, for ease of observation. An explanatory table shows all the areas and sub-areas with the five grades alongside.

Maslow’s hierarchy of need.

To obtain a score, follow the instructions in this manual. The explanatory table gives brief examples of care in all sub-areas/items for all the five grades. From these, scores for the areas are decided.
Instructions

The Graded Care Profile (GCP) gives an objective measure of care of a child by a carer. It gives a qualitative grading for actual care delivered to a child taking account of commitment and effort shown by the carer. Personal attributes of the carer, social environment or attributes of the child are not accounted for unless actual care is observed to be affected by them. Thus, if a child is provided with good food, good clothes and a safe house the GCP will score better irrespective of the financial situation. The grades are on a 1–5 scale (see table 1). Grade one is the best and five the worst. This grading is based on how carer(s) respond to the child’s needs. This is applied in four areas of need – physical, safety, love and esteem. Each area is made up of different sub-areas and some sub-areas are further broken down into different items of care. The score for each area is made up of scores obtained for its items. An explanatory table is prepared giving brief examples of levels of care for the five grades against each item or sub-area of care. Scores are obtained by matching information elicited in a given case with those in the explanatory table. This is taken advantage of in designing the follow-up and targeting intervention. Methods are described below in detail. It can be scored by the carers/s themselves if need be or practicable.

Areas of Care

Maslow, A. 1954

Nutrition, Housing, Clothing, Hygiene & Health
How it is organised.

It has three main components, which are described below.

1. The explanatory table

The explanatory table, which starts at page 13, is laid out in areas, sub areas and items. There are four ‘areas’ – physical, safety, love and esteem which are labelled as – A, B, C and D respectively. Each area has its own ‘sub-areas’, which are labelled numerically – 1, 2, 3, 4 and 5. Some of the ‘sub-areas’ are made up of different ‘items’ which are labelled as – a, b, c, d. Thus the unit for scoring is an ‘item’ (or a ‘sub-area’ where there are no items). See table 2 which shows Area A (physical), sub-area 1 (nutrition) and item a (quality).

Table 2

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
<th>2 child first</th>
<th>3 child and carer equal</th>
<th>4 child second</th>
<th>5 child not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Nutrition</td>
<td>Aware and thinks ahead; provides excellent quality food and drink.</td>
<td>Aware and manages to provide reasonable quality food and drink.</td>
<td>Provision of reasonable quality food, inconsistent through lack of awareness or effort.</td>
<td>Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.</td>
<td>Quality not a consideration at all or lies about quality.</td>
</tr>
</tbody>
</table>

For some of the sub-areas or items there are age bands written in bold italics. Stimulation, a sub-area of the area ‘esteem’, is made up of ‘sub-items’ for age bands 0 – 2, 2 – 5 & above 5 years. Clearly, only one will apply in any case.

2. The scoring sheet

There is a scoring sheet, which accommodates the entire system down to the items. It gives an overview of all scores and should be completed as the scores are decided from the explanatory table. See table 3.

Table 3
3. The summary sheet

It is printed on an A4 sheet. At the top there is room to make note of personal details, date and to note who the main carer about whom the scoring is done. ‘Areas’ and ‘sub-areas’ are in a column vertically on the left hand side and scores (1 to 5) in a row of boxes horizontally against each sub-area. Next to this is a rectangular box for noting the overall score for the area, which is worked from the scores in sub-areas (described later). Next to the area score, there is another box to accommodate any comments relating to that area. See table 4. At the bottom there is a separate table designed to target sub-area(s) or item(s) where care is particularly deficient and to follow them up.

Table 4

<table>
<thead>
<tr>
<th>Area</th>
<th>Sub-Area</th>
<th>Scores</th>
<th>Area Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>1. NUTRITION</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. HOUSING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. CLOTHING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. HYGIENE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. HEALTH</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Workers who have used this say that although it looks complicated at first, it gets easier once familiar with the tool.
How to use

1. Discuss with the parent or carer your wish to complete a GCP with them. Go through the parents’ leaflet with them and leave them a copy. Once you are sure they have understood, ask them to sign the consent form on the summary sheet. Fill in the relevant details at the top of the record sheet. Keep the form for your records and note that consent has been given in your case recording system.

2. The Main Carer: is the main carer present when you do the graded care profile. It can be either or both parents, or another main carer. Note who is involved in the top right corner of the record sheet.

3. Methods: It is necessary to do a home visit to make observations. You need to be familiar with the area headings to be sure everything is covered during one or more visits. This document can be shared with the family during the visit, or you can fill it in afterwards. Carers using it themselves can simply go through the explanatory table.

4. Situations:
   a) As far as possible, use the usual state of the home environment and don’t worry about any short term, smaller upsets e.g. no sleep the night before.
   b) Don’t take into account any external factors on the environment (e.g. house refurbished by welfare agency) unless carers have positively contributed in some way by keeping it clean, adding their own bits in the interest of the child like a safe garden, outdoor or indoor play equipment or safety features etc.
   c) Allowances should be made for background factors, e.g. bereavement, recent loss of job, illness in parents. It may be necessary to revisit and score at another time.
   d) If the carer is trying to mislead deliberately by giving the wrong impression or information in order to make one believe otherwise- score as indicated in the explanatory table. (e.g. ‘misleading explanations’- for PHYSICAL Health/follow up would score 5. and ‘any warmth/guilt not genuine’ for LOVE Carer/reciprocation would score 5).

5. Once completed, share a copy with the parents with whom you have completed it and ask them to sign to say they have seen the completed profile. Send them a copy as soon as possible.
Obtaining information on different items or sub-areas:-

A) Physical

1. Nutritional: (a) Quality (b) Quantity (c) Preparation and (d) Organisation

Take a history about the meals provided including nutritional contents (milk, fruits etc.), preparation, set meal times, routine and organisation. Also note carer’s knowledge about nutrition, note carer’s reaction to suggestions made regarding nutrition (whether keen and accepting or dismissive). Observe for evidence of provision, kitchen appliances and utensils, dining furniture and its use without being intrusive. It is important not to lead as far as possible but to observe the responses carefully for honesty. Observation at a meal time in the natural setting (without special preparation) is particularly useful. Score on amount offered and the carer’s intention to feed younger children rather than actual amount consumed as some children may have eating/feeding problems.

2. Housing (a) Maintenance (b) Décor (c) Facilities

Observe. If lacking, ask to see if effort has been made to improve, ask yourself if carer is capable of doing them him/herself. It is not counted if repair or decoration is done by welfare agencies or landlord.

3. Clothing (a) Insulation (b) Fitting (c) Look

Observe. See if effort has been made towards repairing, cleaning and ironing. Refer to the age band in the explanatory table.

4. Hygiene

Child’s appearance (hair, skin, behind ears and face, nails, rashes due to long term neglect of cleanliness, teeth). Ask about daily routines. Refer to age band in explanatory table.

5. Health (a) Opinion sought (b) Follow-up (c) Health checks and immunisation (d) Disability/Chronic illness

Ask who is consulted on matters of health, and who decides when health care is needed. Check about immunisation uptake, reasons for non-attendance if any, see if reasons are valid. Check with relevant professionals. Distinguish genuine difference of opinion between carer and professional from non-genuine misleading reasons. Beware of being over sympathetic with carer if the child has a disability or chronic illness. Remain objective.

B) Safety

1. In Presence (a) Awareness (b) Practice (c) Traffic (d) Safety features

This means how safely the home environment is organised. It includes safety features and carer’s behaviour regarding safety (e.g. lit cigarettes,
safety fixtures and equipment in and around the house or in the car (child safety seat etc.) by observing carers handling of young babies and supervision of toddlers. Also observe how carer instinctively reacts to the child being exposed to danger. If observation not possible, then ask about the awareness. Observe or ask about child being allowed to cross the road, play outdoors etc. along the lines in this manual. If possible check answers out with other sources. Refer to the age band where indicated.

2. In Absence: This covers child care arrangements where the carer is away, taking account of reasons and period of absence and age of the minder. This itself could be a matter for concern in some cases. Check answers out with other sources.

C) Love

1. Carer  (a) Sensitivity  (b) Timing of response (c) Reciprocation (quality of response)

This mainly relates to the carer’s relationship with the child. Sensitivity means where carer shows awareness of any signal from the child. Carer may become aware yet respond a little later in certain circumstances. Note the timing of the carer’s response in the form of appropriate action in relation to the signal from the child. Reciprocation means the emotional quality of the response.

2. Mutual engagement (a) Beginning interactions (b) Quality

Observing what goes on between the carer and child during feeding, playing and other activities gives you a sense of whether both are actively engaged. Observe what happens when the carer and the child talk, touch, seek each other out for comfort and play, babies reaching out to touch while feeding or stop feeding to look and smile at the carer. Skip this part if child is known to have behavioural problems as it may become unreliable.

Contact between carer and child that is unplanned is the best opportunity to observe these items. See if carer spontaneously talks to the child or responds when the child talks or makes noises. Note who gets pleasure from this, the carer and the child, either or neither. Note if it is play or functional (e.g. feeding etc.).

D) Esteem

1. Stimulation: Observe or enquire how the child is encouraged to learn. Talking and making noises, interactive play, nursery rhymes or joint story reading, learning social rules, providing fun play equipment are such examples with infants (0 – 2 years). If lacking, try to note if it was due to carer being occupied by other essential chores. Follow the explanatory table for appropriate age band. The four elements (i, ii, iii and iv) in age band 2-5 years and 5- years provide a comprehensive picture. Score in one of the items is enough. If more items are scored, score for which
ever column describes the case best. In the event of a tie choose the higher score (also described in the explanatory table).

2. Approval: Find out how child’s achievement is rewarded or neglected. It can be assessed by asking how the child is doing or simply by praising the child and noting the carer’s response (agrees with delight or child’s successes rejected or put down).

3. Disapproval: If opportunity presents, observe how the child is told off, otherwise enquire carefully (Does the child throw tantrums? How do you deal with it if it happens when you are tired yourself?) Beware of any difference between what is said and what is done. Any observation is better in such situations than the carer’s description e.g. child being ridiculed or shouted at. Try and ask more if carer is consistent.

4. Acceptance: Observe or ask how carer generally feels after she/he has told the child off, or when the child has been told off by others (e.g. teacher), when child is not doing well, or feeling sad for various reasons. See if the child is rejected (put down) or accepted at these times with warm and supportive behaviour.

### Scoring on the explanatory table

Make sure your information is factual as far as possible. Go through explanatory table – (Sub-Areas and Items). Find the description which matches best, read one grade on either side to make sure, then place a tick on that description (photocopy the score sheet to use each time). The number at the top of the column will be the score for that item or sub-area. Where more than one item represents a sub-area, use the method described below to obtain the score for the sub-area.

### Obtaining a score for a sub-area from its items’ scores.

Transfer the scores from the explanatory table to the scoring sheet for the items (and sub areas without items i.e. hygiene). Read the score for all the items of a particular sub-area: if there is a clearly repeated number but none of the ticks are beyond 3, score that number for that particular sub-area. To record it on the scoring sheet enter the number in the box for that sub-area. Example: the scores for the items average 2 so the sub area score is 2.

<table>
<thead>
<tr>
<th>AREAS</th>
<th>PHYSICAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub areas</td>
<td>NUTRITION</td>
<td></td>
</tr>
<tr>
<td>Items</td>
<td>quality</td>
<td>quantity</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>a</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
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<tr>
<td>d</td>
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</tr>
</tbody>
</table>

10
If there is even a single score of 4 or 5, score that point regardless of other scores. *
Example: the scores for the items average 3, but there is a score of 4, so the sub area score is 4.

Obtaining a score for an ‘area’

Follow the same principle for getting an overall score for an area by taking an average of the sub-area scores. Again, if there is even a single score of 4 or 5, score that point regardless of other scores. *

*This method helps identify the problem even if it is one sub-area or item. Its primary aim is to safeguard child’s welfare while being objective. The average score is not used as it will not show up the high scores which are the areas of concern.
Transferring the scores to the summary sheet:
Transfer all scores in double boxes from the scoring sheet to the summary sheet. This will be the sub area and area scores.

Comments:
This column in the summary sheet can be used for flagging up issues, which are not detected by the profile but may be relevant in a particular case. For example, a child whose behaviour is difficult or a parent whose over protectiveness gives rise to concern. Comments noted may then lead to additional support.

Targeting:
If a particular sub-area scores highly, it can be noted in the table at the bottom of the summary sheet. A better score can be aimed at after a period of work. Aiming for one grade better will place less demand on the carer than by aiming for the ideal in one leap.
## Explanatory table

### A Area of physical care

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
<th>2 child first</th>
<th>3 child and carer equal</th>
<th>4 child second</th>
<th>5 child not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Nutrition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Quality</td>
<td>Aware and thinks ahead; provides excellent quality food and drink.</td>
<td>Aware and manages to provide reasonable quality food and drink.</td>
<td>Provision of reasonable quality food, inconsistent through lack of awareness or effort.</td>
<td>Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.</td>
<td>Quality not a consideration at all or lies about quality.</td>
</tr>
<tr>
<td>c. Preparation</td>
<td>Painstakingly cooked/prepared for the child.</td>
<td>Well prepared for the family always thinking of the child’s needs.</td>
<td>Preparation infrequent and mainly for the adults, child sometimes thought about.</td>
<td>More often no preparation. If there is, child’s need or taste not thought about.</td>
<td>Hardly ever any preparation. Child lives on snacks, cereals or takeaways.</td>
</tr>
<tr>
<td>d. Organisation</td>
<td>Explanatory table</td>
<td>Area of physical care continued …</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------</td>
<td>------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>Meals carefully</td>
<td>1. child priority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>organised –</td>
<td>2. child first</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>seating, timing,</td>
<td>3. child and carer equal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>manners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaotic – eat</td>
<td>4. child second</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and what one</td>
<td>5. child not considered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>can.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorly organised- irregular timing, improper seating.</td>
<td>1. child priority</td>
<td>Area of physical care continued …</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well organised- often seating, regular timing.</td>
<td>2. child first</td>
<td>3. child and carer equal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ill organised- no clear meal time.</td>
<td>4. child second</td>
<td>5. child not considered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>a. Maintenance</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of physical care continued …</td>
<td>2. Housing</td>
</tr>
<tr>
<td>Additional features benefiting child- safe, warm and clean (also referred to B-safety area/1/d)</td>
<td>1. child priority</td>
</tr>
<tr>
<td>State of repair adequate.</td>
<td>2. child first</td>
</tr>
<tr>
<td>In need of decoration but reasonably clean.</td>
<td>3. child and carer equal</td>
</tr>
<tr>
<td>Long term engrained dirt. (Bad odour).</td>
<td>4. child second</td>
</tr>
<tr>
<td>Good, child’s taste considered (practical constraints prevent a score of 1).</td>
<td>5. child not considered</td>
</tr>
<tr>
<td>Excellent, child’s taste specially considered.</td>
<td>1. child priority</td>
</tr>
<tr>
<td>State of repair adequate.</td>
<td>2. child first</td>
</tr>
<tr>
<td>In need of decoration but reasonably clean.</td>
<td>3. child and carer equal</td>
</tr>
<tr>
<td>Long term engrained dirt. (Bad odour).</td>
<td>4. child second</td>
</tr>
<tr>
<td>Good, child’s taste considered (practical constraints prevent a score of 1).</td>
<td>5. child not considered</td>
</tr>
<tr>
<td>c. Facilities</td>
<td>Essential and additional fixtures and fittings - good heating, shower and bath, play and learning facilities.</td>
</tr>
</tbody>
</table>

NOTE: Discount any direct external influences like repair done by other agency but count if the carer has spent a loan or a grant on the house or had made any other personal effort towards house improvement.
<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>Explanatory table of physical care continued to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cloth</td>
<td></td>
</tr>
<tr>
<td>a. Insulation</td>
<td>Well protected with high quality clothes.</td>
</tr>
<tr>
<td>b. Fitting</td>
<td>Excellent fitting and design.</td>
</tr>
<tr>
<td>c. Look-age 0-5</td>
<td>Newish, clean, ironed.</td>
</tr>
<tr>
<td>2. Child priority</td>
<td></td>
</tr>
<tr>
<td>3. Child and carer equal</td>
<td></td>
</tr>
<tr>
<td>4. Child second</td>
<td></td>
</tr>
<tr>
<td>5. Child not considered</td>
<td></td>
</tr>
<tr>
<td>Area of physical care continued to...</td>
<td></td>
</tr>
<tr>
<td>a. Insulation</td>
<td>Well protected with high quality clothes.</td>
</tr>
<tr>
<td>b. Fitting</td>
<td>Proper fitting even if handed down.</td>
</tr>
<tr>
<td>c. Look-age 0-5</td>
<td>Effort to restore any wear. Clean and ironed.</td>
</tr>
<tr>
<td>Area of physical care continued to...</td>
<td></td>
</tr>
<tr>
<td>a. Insulation</td>
<td>Dangerously exposed.</td>
</tr>
<tr>
<td>b. Fitting</td>
<td>Grossly improper fitting.</td>
</tr>
<tr>
<td>c. Look-age 0-5</td>
<td>Dirty, badly worn and crumpled.</td>
</tr>
</tbody>
</table>

- **Explanatory Table**
  - **Sub-areas**
    - **1. Clothing**
      - a. Insulation: Well protected, even if with cheaper clothes.
      - b. Fitting: Proper fitting even if handed down.
      - c. Look-age 0-5: Effort to restore any wear. Clean and ironed.
    - **2. Child priority**
    - **3. Child and carer equal**
    - **4. Child second**
    - **5. Child not considered**

- **Areas of Physical Care Continued to...**
  - **Sub-areas**
    - **1. Clothing**
      - a. Insulation: Dangerously exposed.
      - b. Fitting: Grossly improper fitting.
      - c. Look-age 0-5: Dirty, badly worn and crumpled.
  - **2. Child priority**
  - **3. Child and carer equal**
  - **4. Child second**
  - **5. Child not considered**
<table>
<thead>
<tr>
<th>c. Look- age 5+</th>
<th>As above</th>
<th>As above, odour if bed wetter, not otherwise.</th>
<th>Worse than above unless child does own washing. If younger (under 7) gets relatively better clothes.</th>
<th>Same as above unless child does own washing. Even under 7 same as above.</th>
<th>Child unable to help him/herself therefore same as above.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Hygiene</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 0 to 4</td>
<td>Cleaned, bathed and hair brushed more than once a day</td>
<td>Regular, almost daily.</td>
<td>No routine. Sometimes bathed and hair brushed.</td>
<td>Occasionally bathed but seldom hair brushed.</td>
<td>Seldom bathed or clean. Hair never brushed.</td>
</tr>
<tr>
<td>Age 5 to 7</td>
<td>Some independence at above tasks but always helped and supervised.</td>
<td>Reminded and products provided for regularly. Watched and helped if needed.</td>
<td>Irregularly reminded and products provided. Sometimes watched.</td>
<td>Reminded only now and then, minimum supervision.</td>
<td>Not bothered.</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
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<td>-------------------------</td>
<td>---------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td>Not bothered</td>
<td>Fails a needed follow up after reminders.</td>
<td>Fails a needed follow up even if explanations for not attending are given.</td>
<td>Fails a needed follow up even if explanations for not attending are misleading.</td>
<td>Only when illness becomes critical to children, emergencies or even that ignored.</td>
</tr>
<tr>
<td></td>
<td>Reminded, followed, helped regularly.</td>
<td>Reminded regularly, and encouraged if lapses.</td>
<td>Irregularly, products not provided consistently.</td>
<td>Left to their own initiatives.</td>
<td>Not bothered</td>
</tr>
<tr>
<td></td>
<td>On illness of any severity. Or frequent unnecessary consultation and/or medication.</td>
<td>From professionals/experienced adults on matters of genuine and immediate concern about child health.</td>
<td>Only when illness becomes moderately severe (delayed consultation).</td>
<td>When illness becomes critical to children, emergencies or even that ignored.</td>
<td>Not bothered</td>
</tr>
<tr>
<td></td>
<td>Health opinion sought not only on illness but also other genuine health matters thought about in advance and with sincerity.</td>
<td></td>
<td>When illness becomes critical to children, emergencies or even that ignored.</td>
<td></td>
<td>Not bothered</td>
</tr>
<tr>
<td></td>
<td>All appointments kept. Rearranges if problems.</td>
<td>Fails one in two appointments due to doubt about their usefulness or due to pressing practical inconvenience.</td>
<td>Fails one in two appointments even if of clear benefit for reasons of personal inconvenience.</td>
<td>Attends third time after reminder. Doubts its usefulness even if it is of clear benefit to the child.</td>
<td>Fails a needed follow up a third time despite reminders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Falls one in two appointments even if of clear benefit for reasons of personal inconvenience.</td>
<td></td>
<td></td>
<td>Fails a needed follow up a third time despite reminders.</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
### c. Health checks and immunisation

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to date with scheduled health checks and immunisation unless exceptional or practical problems. Plans in place to address this.</td>
<td></td>
</tr>
<tr>
<td>Omission for reasons of personal inconvenience, takes up if persuaded.</td>
<td></td>
</tr>
<tr>
<td>Omissions because of carelessness, accepts if accessed at home.</td>
<td></td>
</tr>
<tr>
<td>Clear disregard of child’s welfare. Blocks home visits.</td>
<td></td>
</tr>
</tbody>
</table>

Visits in addition to the scheduled health checks, up to date with immunisation unless genuine reservations.

Up to date with scheduled health checks and immunisation unless exceptional or practical problems. Plans in place to address this.

Omission for reasons of personal inconvenience, takes up if persuaded.

Omissions because of carelessness, accepts if accessed at home.

Clear disregard of child’s welfare. Blocks home visits.

### d. Disability/chronic illness (3 months after diagnosis)/illness

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance excellent, (any lack is due to difference of opinion). Compassion for child’s needs.</td>
<td></td>
</tr>
<tr>
<td>Any lack of compliance is due to pressing practical reason. Compassion for child’s needs.</td>
<td></td>
</tr>
<tr>
<td>Compliance is lacking from time to time for no pressing reason (excuses). Shows some compassion for child’s needs.</td>
<td></td>
</tr>
<tr>
<td>Compliance frequently lacking for trivial reasons, very little affection, if at all. Shows little compassion for child’s needs.</td>
<td></td>
</tr>
<tr>
<td>Serious compliance failure (medication not given for no reason), can lie, (inexplicable deterioration). Shows no compassion for child’s needs.</td>
<td></td>
</tr>
</tbody>
</table>

Compliance = accepting professional advice at any venue and carrying out advice given.
<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
<th>2 child first</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. In Presence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Practice</td>
<td>Pre-mobility age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very cautious with handling and laying down. Seldom unattended.</td>
<td>Cautious whilst handling and laying down, Frequent checks if unattended.</td>
<td>Handling careless. Frequently unattended when laid within the house.</td>
<td>Handling unsafe. Unattended even during care chores (bottle left in the mouth).</td>
<td>Dangerous handling, left dangerously unattended during care chores like bath.</td>
</tr>
<tr>
<td></td>
<td>Acquisition of mobility</td>
<td>Constant attention to safety and effective measures against any perceived dangers when up and about.</td>
<td>Effective measures against any danger about to happen.</td>
<td>Measures taken against danger about to happen of doubtful use.</td>
<td>Ineffective measures if at all. Improvement from mishaps soon lapses.</td>
</tr>
<tr>
<td></td>
<td>Infant school</td>
<td>Close supervision indoors and outdoors.</td>
<td>Supervision indoors. No direct supervision outdoors if known to be at a safe place.</td>
<td>Little supervision indoors or outdoors. Acts if in noticeable danger.</td>
<td>No supervision, Intervenes after mishaps which soon lapses again.</td>
</tr>
</tbody>
</table>

**NOTE:** Please refer to the item ‘d (Safety Features)’ and the note below it.
Cumbria Local Safeguarding Children Board

Junior and Senior School

Allows out in known safe surroundings within appointed time. Checks if goes beyond set boundaries.

Can allow out in unfamiliar surroundings if thought to be safe and in knowledge. Reasonable time limit. Checks if worried.

Not always aware of whereabouts outdoors believing it is safe as long as returns in time.

Not bothered about daytime outings, concerned about late nights in case of child younger than 13.

Not bothered despite knowledge of dangers outdoors—railway lines, ponds, unsafe building, or staying away until late evening/night.

Explanatory table

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. In Presence cont.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Traffic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 0–4</td>
<td>Well secured in the pram, harnesses, or when walking, hand clutched. Walks at child’s pace.</td>
<td>3–4 year old allowed to walk but close by, always in vision, hand clutched if necessary i.e. crowd.</td>
<td>Infants not secured in pram. 3–4 year old expected to catch up with adult when walking, glances back now and then if left behind.</td>
<td>Babies not secured, 3–4 year olds left far behind when walking or dragged with irritation.</td>
<td>Babies unsecured, careless with pram, 3–4 year old left to wander and dragged along in frustration when found.</td>
</tr>
<tr>
<td>5 and above</td>
<td>5–10 year old escorted by adult crossing a busy road, walking close together.</td>
<td>5–6 year old allowed to cross road with a 13+ child; 8–9 allowed to cross alone if they reliably can.</td>
<td>5–7 year olds allowed to cross with an older child, (but below 13) and simply watched; 8–9 crosses alone.</td>
<td>5–7 year old allowed to cross a busy road alone in belief that they can.</td>
<td>A child, 7, crosses a busy road alone without any concern or thought.</td>
</tr>
<tr>
<td>d. Safety Features</td>
<td>Abundant features-gate, guards, drug lockers, electrical safety devices, intercom to listen to the baby, safety with garden pond and pool etc.</td>
<td>Essential features-secure doors, windows and any heavy furniture item. Safe gas and electrical appliances, drugs and toxic chemicals out of reach, smoke alarm. Improvisation and DIY if cannot afford.</td>
<td>Lacking in essential features, very little improvisation or DIY (done too causally to be effective).</td>
<td>No safety features. Some possible hazard due to disrepair (tripping hazard due to uneven floor, unsteady heavy fixtures, unsafe appliances).</td>
<td>Definite hazard for disrepair- exposed electric wires and sockets, unsafe windows (broken glass), dangerous chemicals carelessly lying around.</td>
</tr>
</tbody>
</table>

Note: This item along with other safety provisions which are not a fixture like a bicycle helmet, safety car seats, sports safety wear etc. can be used to score for item 'a' (Awareness of safety).
## Explanatory table

### Area of care of safety continued …

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
<th>2 child first</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2. Safety in Absence</td>
<td>Child is left in care of a vetted adult. Never in sole care of an under 16.</td>
<td>Out of necessity a child aged 1-12 is left with a young person over 13 who is familiar and has no significant problem, for no longer than necessary. Above arrangement applies to a baby only in an urgent situation.</td>
<td>For recreational reason leaves a 0-9 year old with a child aged 10-13 or a person known to be unsuitable.</td>
<td>For recreational reason a 0-7 year old is left with an 8-10 year old or an unsuitable person.</td>
<td>For recreational reason a 0-7 year old is left alone or in the company of a relatively older but less than 8 year old child or an unsuitable person.</td>
</tr>
</tbody>
</table>
Explanatory table

C Area of care of love

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a Sensitivity</td>
<td>Looks for or picks up very subtle signals - verbal or nonverbal expression or mood.</td>
<td>Understands clear signals – distinct verbal or clear nonverbal expression.</td>
<td>Not sensitive enough – messages and signals have to be intense to make an impact e.g. crying.</td>
<td>Quite insensitive – needs repeated or prolonged intense signals.</td>
<td>Insensitive to even sustained intense signals or dislikes child.</td>
</tr>
<tr>
<td>b Timing of response</td>
<td>Responds at time of signals or even before in anticipation</td>
<td>Responds mostly at time of signals except when occupied by essential chores.</td>
<td>Does not respond at time of signals if during own leisure activity. Responds at time of signals if fully unoccupied or child in distress.</td>
<td>Even when child in distress responses delayed.</td>
<td>No responses unless a clear mishap for fear of being accused.</td>
</tr>
<tr>
<td>c Reciprocation (quality)</td>
<td>Responses fit with the signal from the child, both emotionally (warmth) and materially (food, nappy change). Can get over stressed by distress signals from child. Warm.</td>
<td>Material responses (treats etc.) lacking, but emotional responses warm and reassuring.</td>
<td>Emotions warm towards child if in good mood (not burdened by strictly personal problem), otherwise flat.</td>
<td>Emotional response brisk and flat. Annoyance if child in moderate distress but attentive if in severe distress.</td>
<td>Disliking and blaming even if child in distress, acts after a serious mishap mainly to avoid being accused, any warmth/guilt not genuine.</td>
</tr>
</tbody>
</table>
### Explanatory table

**Area of care of love continued .....**

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
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</thead>
<tbody>
<tr>
<td><strong>2. Mutual Engagement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b, Quality</td>
<td>Frequent pleasure of engagement, both enjoy it, carer may seem to enjoy a bit more.</td>
<td>Quite often and both enjoy equally.</td>
<td>Less often engaged for pleasure, child enjoys more. Carer passively joins in getting some enjoyment at times.</td>
<td>Engagement mainly for a practical purpose. Indifferent when child attempts to engage for pleasure. Child can get some pleasure (attempts to sit on knees, tries to show a toy).</td>
<td>Dislikes it when child tries to enjoy interactions, if any. Child resigned or plays on own. Carer’s engagement for practical reasons only (dressing, feeding).</td>
</tr>
</tbody>
</table>

**Caution:** If child has temperamental/behavioural problems, scoring in this sub-area (mainly quality item) can be affected unjustifiably. Scoring should be done on the basis of score in area of ‘carer’ (C/1) alone and problem noted as comments.
<table>
<thead>
<tr>
<th>Sub-areas</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Stimulation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age 0-2 years</strong></td>
<td>Plenty of appropriate stimulation (talking, touching, looking). Plenty of equipment</td>
<td>Enough and appropriate intuitive stimulation (See below), less showy toys, gadgets, outings and celebrations</td>
<td>Inadequate and inappropriate - baby left alone while carer pursues own amusements; sometimes interacts with baby.</td>
<td>Baby left alone while adult gets on with pursuing own amusements unless strongly sought out by the baby.</td>
<td>Absent - even mobility restricted (confined in chair/pram) for carer's convenience. Cross if baby demands attention.</td>
</tr>
<tr>
<td><strong>Age 2-5 years</strong></td>
<td>i Interactive stimulation (talking to, playing with, reading stories and topics) plenty and good quality. ii Toys and gadgets (items of uniform, sports equipment, books etc.) - Plenty and good quality. iii Outings (taking the child out for recreational purposes) - frequent visits to child centred places locally and away. iv Celebrations – both seasonal and personal, child made to feel special</td>
<td>i Sufficient and of satisfactory quality. ii Provides all that is necessary and tries for more, make do if unaffordable. iii Enough visits to child centred places locally (e.g. parks) occasionally away (e.g. Legoland, zoos). iv Equally keen and eager but less showy.</td>
<td>i Variable-adaptable if usually doing own thing. ii Essentials only. No effort to make do if unaffordable. iii Child accompanies carer wherever carer decides, usually child friendly places. iv Mainly seasonal (Christmas) low key personal (birthdays).</td>
<td>i Scarce - even if doing nothing else. ii Lacking on essentials. iii Child simply accompanies carer where carer decides, usually child friendly places. iv Only seasonal-low key to keep up with the rest.</td>
<td>i Nil. ii Nil, unless provided by other sources - gifts or grants. iii No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. iv Even seasonal festivities absent or dampened.</td>
</tr>
</tbody>
</table>
### Explanatory table  Area of care of esteem continued

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1. Stimulation cont.</th>
<th>2. Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age 5+ years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i Education – active interest in schooling and support at home.</td>
<td>Talks about the child with delight/praise without being asked; material and generous emotional reward for any achievement.</td>
</tr>
<tr>
<td></td>
<td>ii Sports and leisure – well organised outside school hours e.g. swimming, clubs, etc.</td>
<td>Talks fondly about the child when asked, generous praise and emotional reward, less of material reward.</td>
</tr>
<tr>
<td></td>
<td>iii Friendships – encouraged and checked out</td>
<td>Agrees with other’s praise of the child, low key praise and damp emotional reward.</td>
</tr>
<tr>
<td></td>
<td>iv Provision – stylish e.g. sports gear, computers.</td>
<td>Indifferent if child praised by others, indifferent to child’s achievement, which is quietly acknowledged.</td>
</tr>
</tbody>
</table>

### NOTE: Whichever describes the case best should be ticked as the score; in the event of a tie choose the higher score.

<table>
<thead>
<tr>
<th>1. Stimulation cont.</th>
<th>2. Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>i Active interest in schooling, support at home when can.</td>
<td>i Little effort to maintain schooling or mainly for other reasons like free meals etc.</td>
</tr>
<tr>
<td>ii All affordable support.</td>
<td>ii Child makes all the effort, carer not bothered.</td>
</tr>
<tr>
<td>iii Carer offers some help.</td>
<td>iii Child finds own friends, no help from carer unless reported to be bullied.</td>
</tr>
<tr>
<td>iv Well provided and tries to provide more if could.</td>
<td>iv Under provided.</td>
</tr>
<tr>
<td>i Maintains schooling but little support at home even if has spare time.</td>
<td>i Not bothered or can even be discouraging.</td>
</tr>
<tr>
<td>ii Little effort in finding out but takes up opportunities at doorstep.</td>
<td>ii Not bothered even if child is doing unsafe/unhealthy activity.</td>
</tr>
<tr>
<td>iii Accepts if a friend is from a supportive family with carer.</td>
<td>iii Not bothered.</td>
</tr>
<tr>
<td>iv Poorly provided.</td>
<td>iv No provision.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. child and carer equal</th>
<th>4. child second</th>
<th>5. child not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>i Little effort to maintain schooling or mainly for other reasons like free meals etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii Child makes all the effort, carer not bothered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii Child finds own friends, no help from carer unless reported to be bullied.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv Under provided.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Approval
Explanatory table

Area of care of esteem continued

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child priority</th>
<th>2 child first</th>
<th>3 child and carer equal</th>
<th>4 child second</th>
<th>5 child not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Disapproval</td>
<td>Mild verbal and consistent disapproval if any set limit is crossed.</td>
<td>Consistent terse verbal, mild physical, mild sanctions if any set limits are crossed.</td>
<td>Inconsistent boundaries or methods terse/shouts or ignores for own convenience, mild physical and moderate other sanctions.</td>
<td>Inconsistent,-shouts/harsh verbal, moderate physical, or severe other sanctions.</td>
<td>Terrorised. Ridicule, severe physical or cruel other sanctions.</td>
</tr>
<tr>
<td>4. Acceptance</td>
<td>Unconditional acceptance. Always warm and supportive even if child is failing.</td>
<td>Unconditional acceptance, even if temporarily upset by child’s behavioural demand but always warm and supportive.</td>
<td>Annoyance at child’s failure, behavioural demands less well tolerated.</td>
<td>Unsupportive to rejecting if child is failing or if behavioural demands are high. Accepts if child is not failing.</td>
<td>Indifferent if child is achieving but rejects if makes mistakes or fails. Exaggerates child’s mistakes</td>
</tr>
</tbody>
</table>

NOTE: If the style of parenting (over protective, permissive to foster independence, authoritarian) or type of values instilled is of concern, please make a note in the corresponding comment box on the record sheet.
Scoring sheet

This is the scheme representing all 'items' (represented by small letters), 'sub areas' (represented by numbers), and 'areas' (represented by capital letters) These are printed in circles. Scores are to be noted in boxes adjacent to corresponding 'items', 'sub areas', and 'areas'. This represents the entire record as in the explanatory table for full reference.
Summary sheet

Name (Child) __________________________ Date of Birth __________________________
Main Carer/s ________________________________________________________________
Carer/s signature/s of consent to complete a GCP ________________________________

Scorer’s Name __________________________ Scorer’s Signature __________________________ Date __________

<table>
<thead>
<tr>
<th>Area</th>
<th>Sub-Area</th>
<th>Scores</th>
<th>Area Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Physical</td>
<td>1. NUTRITION</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. HOUSING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. CLOTHING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. HYGIENE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. HEALTH</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Safety</td>
<td>1. IN CARER’S PRESENCE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. IN CARER’S ABSENCE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Love</td>
<td>1. CARER</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. MUTUAL ENGAGEMENT</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Esteem</td>
<td>1. STIMULATION</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. APPROVAL</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. DISAPPROVAL</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. ACCEPTANCE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Targeting Particular Item of Care:-
Any item with disproportionately high score can be identified by reference to the explanatory table by writing the area, sub area and item i.e. physical/nutrition/quality in the table below.

<table>
<thead>
<tr>
<th>Targeted items (area/sub area/item)</th>
<th>Current Score</th>
<th>Period for change</th>
<th>Target Score</th>
<th>Actual Score after first review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have seen the completed GCP scores for my child.
Parent/ carer comments

Signed __________________________ Date __________

30
## Cumbria LSCB Scaling Tool

<table>
<thead>
<tr>
<th>Scale</th>
<th>Team</th>
<th>Criteria/Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Child Protection</td>
<td>Little evidence of risk of harm decreasing or further harm identified. The local authority to consider the use of public law outline or legal proceedings.</td>
</tr>
<tr>
<td>2</td>
<td>Child Protection</td>
<td>Initial Child Protection Conference convened and a multi-agency decision about risk of harm agreed. Children will be subject to child protection planning. If progress is evidenced, step down to Child in Need or Early Help to be discussed in the Core Group prior to the Review Child Protection Conference.</td>
</tr>
<tr>
<td>3</td>
<td>Child In Need</td>
<td>Children’s needs are not being consistently met by parents despite CIN plan. Children not being consistently kept safe from harm. This may be a single incident or an accumulation of events. Strategy Meeting initiated and multi-agency decision for Section 47 enquiries required.</td>
</tr>
<tr>
<td>4</td>
<td>Child In Need</td>
<td>Child and Family demonstrate commitment to change and willingness to engage but progress against plan is slower than expected. Step down from child protection plan to CIN plan, parents have evidenced that they can keep their children safe and the children are no longer at risk of significant harm.</td>
</tr>
<tr>
<td>5</td>
<td>Child In Need</td>
<td>Child and Family assessment meets CIN threshold, child subject to CIN plan led by Social Worker. Child in Need Reviews held six weekly, progress is demonstrated and child/family working towards closure to Child in Need or support via Early Help.</td>
</tr>
<tr>
<td>6</td>
<td>Child and Family Assessment to be undertaken</td>
<td>Threshold met for Child and Family assessment, single contact form put in to the Safeguarding Hub. Outcome of a discussion at the Early Help and Family Support Panel - Child and Family Assessment agreed and Social Work Team Manager will progress this. When a Child and Family Assessment has been completed, following a discussion at the Early Help and Family Support Panel and deemed NFA by Social Care, the Team Manager brings the assessment/case back to the panel to develop an Early Help plan.</td>
</tr>
<tr>
<td>7</td>
<td>Early Help</td>
<td>There is evidence of the plan not progressing or is ‘stuck’ or where there is further unmet needs identified, consideration to be given to what new approach would support change. Agencies should attempt to support family with the new worry. If worries persist contact your Area Early Help Officer to put in referral to the Early Help and Family Support panel. Unmet needs and work undertaken to be evidenced in referral.</td>
</tr>
<tr>
<td>8</td>
<td>Early Help</td>
<td>Team Around Family Meetings will be convened. Child’s needs met through a multi-agency plan. The plan should be SMART focused on the worries and reviewed by TAF membership with family.</td>
</tr>
<tr>
<td>9</td>
<td>Early Help/Universal Services</td>
<td>Support needed from additional agency Early Help Assessment initiated. Multi agency plan coming to a conclusion, child’s needs can be met and monitored via single agency / universal services.</td>
</tr>
<tr>
<td>10</td>
<td>Universal Services</td>
<td>Needs met by Universal Services, e.g. school. Single agency response only.</td>
</tr>
</tbody>
</table>
If concerns arise that indicate a child may be at risk of significant harm, a referral to the Safeguarding Hub must take place if the child is not already open to Children’s Services.

Appendices

Cumbria LSCB Multi Agency Threshold Document

Cumbria LSCB Protocol for Assessment

Working Together to Safeguard Children
Appendix 4
Case Studies

Single Agency Response
Tim is eight years old. Yesterday, Tim’s mum spoke to the Head Teacher at Tim’s primary school because she is worried about Tim. She says she is struggling to get Tim up for school in the morning. Initially, mum thought that this was because he was being lazy, however, recently Tim has told her that another pupil at the school had started to call him names because his dad is disabled and uses a wheelchair. Mum is requesting help from school in giving her some ideas about how to encourage Tim to get into school in the morning and to deal with the issue of the name-calling. Tim has asked his mum not to talk to school about this issue as he is worried that he might get bullied for telling tales.

Strengths
• Mum has a good relationship with school and feels able to talk to school staff.
• In the past Tim’s attendance at school has been good and Tim has always enjoyed school.
• Tim has a happy family life and has good relationships with his parents.

Needs
• Tim to be happy to go to school without being worried about being bullied.
• Tim’s mum to have strategies to get him to school on time.
• Tim to be able to tell his mum or his teacher if he is worried.

Seriousness/Risk
• Tim’s school attendance will drop and he will not meet his educational milestones.
• If Tim is bullied this will affect his friendships and interactions with his peers and he is likely to become isolated and unhappy.

Outcomes
• Tim looks forward to going to school and school report that he is doing well in class and meeting his educational milestones.
• Tim feels confident to stand up for himself and is able to tell an adult if he is bullied.
• Mum reports that Tim’s mood has improved; he is cheerful and is happy to get up for school.

Plan /Actions
School staff and mum agree that for the next two weeks Tim can come into school 5 minutes later than normal which ensures that he will not meet the other pupil in the playground. Teachers will keep a discreet, watchful eye on Tim. Head Teacher is also able to offer Tim a place in a nurture group, however, mum feels this provision is not needed at this time. An assembly takes place in school focusing on the achievement of the athletes in the Paralympics. This aids all students’ understanding of disability, and how having a disability does not necessarily limit people’s achievements. School staff also have a discreet word with the other pupil’s mother and request that she speaks with her child about the issue by introducing a conversation following the Assembly. The Head Teacher continues to meet with mum over the next two weeks to discuss progress and suggests that she begins to use a reward chart to encourage her child’s prompt attendance.

Timescale
Two weeks. To be reviewed in one month.
**Early Help**

Sophie is 22 years old and she lives with Billy, her partner who is 23 years old, and their three children: Bethany, three years old, Lucas, two years old and Jack, who is four months old.

Sophie has told her Health Visitor that she has little support from her family in helping her care for the children. Sophie’s days are filled with meeting the needs of her children throughout the day. She says she feels isolated and she struggles to go out with the children on her own as she worries that one of the older children may run off and she won’t be able to run after them without leaving the other two alone. Her third pregnancy was unplanned. Sophie is struggling to manage Bethany’s behaviour, as she constantly demands attention, especially when she is trying to feed Jack.

Billy works shifts in a low paid job and he is often out of the house for 12 hour periods and sometimes he needs to sleep during the day. Billy says this can prove difficult for him if the children are ‘playing up’. Billy does his share of household tasks and has offered to care for the children if Sophie wants to go out and meet with friends but she has not taken him up on this offer.

Bethany attends pre-school in the mornings. Over the past few months Bethany has been late once or twice a week. The Health Visitor is concerned that Bethany’s speech is noticeably delayed. Sophie says Lucas has always been a placid child, however, over the past few weeks he has had several temper tantrums. She is uncertain if this is because Lucas may now be going through the “terrible twos”, or whether it is because of the home situation.

Jack currently sleeps in his parents room in a cot and there is damp in the room which Sophie and Billy are worried may affect his health. Parents have contacted the Housing Association due to their concerns about the damp in the property and a Housing Officer is due to visit next week to assess whether any remedial work needs to be undertaken.

**Strengths**
- The family have their own home.
- Billy is in full-time employment.
- Bethany is in pre-school.
- Billy shares household tasks and helps with the children.
- Sophie has a wide circle of friends who she used to see regularly before Jack was born.

**Needs**
- Sophie needs to be confident in managing the children’s behaviour so that she is able to take the children out on her own.
- Bethany needs to be able to communicate with the adults in her life.
- Jack needs a place to sleep that is warm and dry.
- Billy needs to have enough sleep so that his work isn’t affected.
- All the children need to have 1-1 time with their parents.

**Seriousness/Risk**
- Sophie is likely to become more isolated and this could impact on both her mental and physical health.
- Bethany will become increasingly frustrated and demanding.
- If Jack continues to sleep in damp surroundings his physical health will deteriorate and he will become prone to chest infections which could become chronic.
- If Billy does not have enough sleep this could affect his work and he may lose his job. This will affect the family’s financial situation.
- Without 1-1 time with their parents all the children may struggle to develop relationships with both their parents and with each other.

**Outcomes**
- Sophie says Bethany is much happier at home.
- Repairs have been made to the family home and Jack’s room is dry.
- Sophie can talk about what she is doing differently when she goes out with the children.
- Sophie is visiting her friends and taking the children to activities outside the home.
• Bethany's speech is improving and both Sophie and workers at pre-school say she is now forming words.
• Sophie and Billy have worked on routines so that Billy gets enough sleep. Billy says he is less tired.

Plan /Actions

The Health Visitor and parents agree that she will make a referral for Bethany to the Speech and Language Therapy Service for support with her speech. From discussions with Sophie, the Health Visitor is aware that a number of agencies are working with the family and she is concerned that mum is beginning to feel a little overwhelmed. The Health Visitor discusses an EHA and parents agree to the assessment.

The Health Visitor reports to the Early Help Team that an EHA needs to be registered.

The Health Visitor completes the EHA with parents and they jointly agree outcomes to meet the needs of the family. A Team Around the Family meeting (TAF) is arranged for two weeks time and parents and the Health Visitor identify which professionals should attend. They agree that the Speech Therapist and the Housing Officer will attend along with Health Visitor and parents. The Health Visitor is aware that Sophie has attended toddler groups at the Children's Centre and has a good relationship with the workers there. She suggests that it would be helpful to invite a worker from the Centre to attend the meeting and parents agree. The meeting is planned at a time which fits with Billy’s work pattern and to take place at the Children’s Centre where there is a crèche the children can attend whilst parents attend the meeting.

At the TAF meeting, a range of actions were agreed by both professionals and parents to achieve the outcomes identified in the EHA. For example:

• The Health Visitor to apply for two year old nursery funding for a nursery place for Lucas.
• Children’s Centre worker to work with mum and dad to: a) identify strategies to manage children’s behaviour, b) establish routines which enable Billy to sleep, c) build Sophie’s confidence so that she feels able to attend some of the groups taking place at the Centre.
• The Speech Therapist and Health Visitor to work with both parents in respect of Bethany’s speech.
• Housing Officer agrees that work was required on the outside of the home to stop the damp. A timescale of two months was set for completion.

At the meeting, it was also agreed that it was beneficial for the EHA to continue so that the plan could be reviewed. Both parents felt that the Health Visitor was the best person to take the role of co-ordinator. This was agreed and she agreed to organise the next meeting to take place in a month. The Housing Officer would report back on the progress of the house repairs at this meeting. The Speech Therapist agreed to feedback information about Bethany’s progress to the Health Visitor. If Bethany’s speech had not improved then she would also attend the meeting. Staff from Lucas's Nursery would also be invited to attend the next meeting.
**Statutory Intervention**

Stephen is 12 years old. He lives with his father and his three brothers Ben, 14 years, David, 9 years, and Luke, 8 years. Concerns arose when Ben was taken to hospital because he was intoxicated. When staff in the A and E department spoke to Ben he refused to go home and said that his dad had hit him. Because of their concerns, A and E staff telephoned the Cumbria Safeguarding Hub. The Cumbria Safeguarding Hub then checked records to establish the family history.

Records showed that Stephen’s parents separated when Stephen was eight years old. He and his brothers remained in the care of their father. Mother now lives 20 miles away with her new partner. The children have contact with their mother in school holidays and occasional weekends. Since the parents separation there have been concerns about father’s care of the children and Children’s Services have been involved on three separate occasions. The most recent involvement was eight months ago when there were concerns about father’s basic care of the children in that the children were reported to be hungry, their attendance at school was erratic, the home was described as dirty with no clean bedding and Luke had missed numerous health appointments for treatment for an eye problem.

Based on this information, the Cumbria Safeguarding Hub Team Manager transferred the case to the Child Protection Team in the District in which Stephen lived and a social worker was allocated to assess the needs of the children. The social worker visited the family and spoke to father and the children. She visited the mother separately. She also gathered information from children’s schools, family GP, school nurse and hospital. This showed a number of serious concerns

- Family home was dirty with sparse and dirty bedding, much of the furniture was broken and the cooker was out of action.
- There was little food in cupboards/fridge that was edible and the children said that they relied on school meals for their main meal of the day.
- Stephen reported that over the past six months there had been two occasions when his father had hit him.
- The children said that their father went out most evenings, sometimes staying out all night. During these times Luke and David were left in the care of Stephen and Ben. Stephen told the social worker he felt protective of his younger brothers.
- Stephen is permanently excluded from school and attends a Pupil Referral Unit. When he attended school he displayed behaviour described as aggressive by his teacher and was disruptive.
- Stephen finds it difficult to control his anger. There have been two incidents when he has had fights with peers which have resulted in a police caution.

In the past, father had worked well with Children’s Services and professionals to address any concerns. However, when the social worker visited father he was reluctant to talk to her and was abusive towards her when she tried to talk about the seriousness of the situation. He dismissed the concerns and demonstrated a lack of insight into the needs of his children. Having spoken to Stephen’s mother, the worker identified inconsistencies about the contact she was having with her children. These breached the Family Proceedings Court Order.

Opposite are some examples of needs and possible outcomes for Stephen. The complexity of the situation should be understood and this is not an exhaustive list and is intended to illustrate how needs and outcomes are identified.

**Strengths**

- Stephen has been able to able to say how he feels.
- Stephen was able to relate to chosen professional.
- Mother wants to work with agencies to secure the care of Stephen.
- Stephen has been accessing education at the Pupil Referral Unit.
- Stephen has a loving relationship with his siblings.
Needs
- A secure home which is clean, has a bed and clean warm bedding, and food to eat which is nourishing and healthy.
- His dad to stop hitting him and his brothers.
- His dad to explain why he hits the children and to understand that this must stop immediately.
- To be cared for by adults he can trust and depend on.
- To continue to attend the Pupil Referral Unit.
- To be able to understand and regulate his behaviour.
- To have strategies to manage his behaviour.
- His dad to understand why professionals are worried about his care of Stephen and the seriousness of the situation.
- To renew his relationship with his mother.

Seriousness/Risk
The family situation is of great concern. Stephen is at risk of being seriously injured by his father. The situation at home is chaotic and Stephen and his brothers’ basic needs are being severely neglected. The ongoing neglect that he faces is likely to have a significant impact on both his physical and emotional development.

Research by David Howe (2005) highlights the risks that Stephen faces in his father’s care:

“It is at this point (early adolescence) that chaotically neglectful parents begin to feel despairingly angry and helpless. They are driven by feelings that their child is unmanageable and ungrateful, unresponsive and unloving. Their child makes them feel incompetent and without value. This can culminate in a situation where after ablazing row or a stormy fight, they might harm their child or abandon them completely. At school, children are at risk of falling significantly behind in their learning. Their socially disruptive behaviour in the classroom may result in suspension. And out in the community, children typically join antisocial gangs where they might get into trouble with the police for vandalism, shoplifting or verbal abuse.”

This description fits with Stephen’s situation. It could be predicted with some degree of certainty that without intervention Stephen’s home situation would deteriorate. His emotional and mental health will deteriorate and he will find it hard to make relationships with others. On this basis his needs - and the needs of his family - could be described as complex.

Outcomes
- Over the next month the social worker reports that on her twice weekly unannounced visits to the family home there is enough food in the fridge to make a healthy meal, the house and Stephen’s bed and bedding are clean.
- Stephen's father can describe what causes him to be angry and to lash out and he has agreed to work with professionals on strategies to change his behaviour.
- Stephen's father has a daily routine which means that basic care has improved.
- Staff at the Pupil Referral Unit report that Stephen is clean, well-fed and arrives with all the things that he needs to help with his learning.
- Father has arranged for an adult to care for the children when he goes out at night.
- Stephen has strategies to manage his anger.
- Stephen's father can say how his behaviour is causing Stephen to be angry.
- Mother reports that Stephen is now visiting her and she and Stephen now have a positive relationship.

Plan /Actions
Due to the serious nature of the concerns and the physical assaults by the father on both Stephen and Ben, a Strategy meeting was convened under child protection procedures. The meeting was chaired by the District Child Protection Team Manager and invitees included representatives from Police, School and Health agencies working with all four boys. At this meeting all professionals agreed that Stephen was at risk of significant harm and this met the threshold for a child protection investigation under Section 47 (Children Act 1989) and that an Initial Child Protection Conference should be convened. A social worker from the Child
Protection team was allocated to work with the family and to undertake a comprehensive assessment of need.

At the conference Stephen and his siblings were made subject to Child Protection Plans and a Core Group was established with the Child Protection Team Social Worker as Lead Professional. A SMART Child Protection Plan based on the needs and outcomes identified was agreed with parents, Core Group members and Stephen and his brothers. The plan clearly specified what needs to change and why, responsibility for the actions within the plan and realistic timescales for completion of action and review dates and what would happen if the actions were not met within the agreed timescales.
Cumbria LSCB

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Website: cumbriaLSCB.com