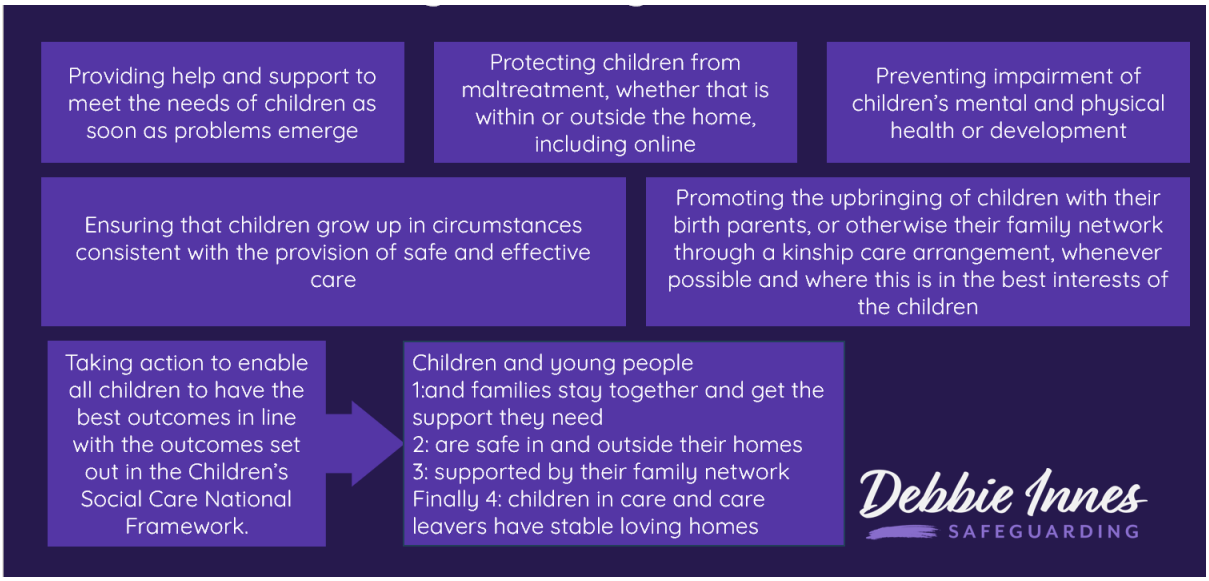
Introduction

The introduction sets out that this guidance applies to every child (defined as anyone who has not yet reached their 18th birthday). It also sets out that anyone who works with children (referred to as practitioners) in any capacity needs to take notice of the guidance. It sets out the definition of safeguarding that all practitioners should be aware of:



The introduction also makes clear the following:

Child protection is part of safeguarding and promoting the welfare of children and is defined for the purpose of this guidance as activity that is undertaken to protect specific children who are suspected to be suffering, or likely to suffer, significant harm. This includes harm that occurs inside or outside the home, including in foster care and residential care, as well as online. Effective safeguarding is anti-discriminatory and anti-racist. Practitioners should understand and be sensitive to factors, including economic and social circumstances, ethnicity and disability, which can impact children and families' lives.

Chapter 1: A Shared Responsibility

Chapter 1 emphasizes the importance of strong partnership working between practitioners, parents, and carers to achieve successful outcomes for children. It advocates for a child-centered approach within a whole-family focus, ensuring that the needs of children are prioritized while considering the dynamics of the entire family.

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Key Principles:

1. **Child-Centered Approach**: Practitioners should prioritize the welfare, wishes, and feelings of children, ensuring they are heard and responded to. Children should be raised within their families or family networks whenever possible.
2. **Whole-Family Focus**: Practitioners should explore the needs of all family members and understand how these needs impact one another.
3. **Partnership with Parents and Carers**: Practitioners should work collaboratively with parents and carers, building trust and supporting them to make positive changes while keeping the child's best interests central to decision-making.
4. **Anti-Discriminatory Practice**: Practitioners should actively address discrimination and inequality, considering economic, social, cultural, and individual factors that impact children and families.

Expectations for Multi-Agency Working:

- **Strategic Leaders**: Develop shared goals, use evidence to evaluate practices, allocate resources, and foster an inclusive culture.
- **Senior and Middle Managers**: Promote collaboration, peer learning, and constructive challenge within and across agencies.
- **Direct Practitioners**: Share information, prioritize the child's voice, and work collaboratively with families and other agencies.

Information Sharing:

Effective sharing of information between practitioners and agencies is critical for early identification, assessment, and service provision to keep children safe. Practitioners should proactively share information, comply with data protection laws, and prioritize transparency with families while ensuring safety.

The chapter underscores the importance of timely, coordinated, and sensitive responses to children's needs, with a focus on building trust and fostering positive relationships with families.

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Chapter 2: Multi-Agency Safeguarding Arrangements

Chapter 2 outlines the framework for **multi-agency safeguarding arrangements (MASAs)**, emphasizing the importance of collaboration among local organizations and agencies to protect children from abuse, neglect, and exploitation. It provides guidance on the roles, responsibilities, and processes for safeguarding partners and relevant agencies.

Key Components of MASAs:

1. **Safeguarding Partners**:
    - Defined as the **local authority**, **integrated care board (ICB)**, and **chief officer of police** for the area.
    - These partners have a joint and equal duty to work together to safeguard and promote the welfare of children.
    - They must set a shared vision, strategic priorities, and allocate resources to deliver effective safeguarding arrangements.
2. **Geography**:
    - MASAs should align with local authority boundaries but can cover multiple areas if agreed upon.
    - Collaboration across police and health boundaries is encouraged to ensure consistency.
3. **Strategic Leadership**:
    - **Lead Safeguarding Partners (LSPs)** (e.g., Chief Executives of local authorities, ICBs, and police forces) are responsible for setting the strategic direction, ensuring accountability, and overseeing the effectiveness of arrangements.
    - **Delegated Safeguarding Partners (DSPs)** are appointed to deliver and monitor multi-agency priorities and procedures.
4. **Relevant Agencies**:
    - Agencies such as schools, early education providers, voluntary organizations, and sports clubs are considered relevant agencies and must cooperate with safeguarding partners.

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- Safeguarding partners should consult relevant agencies when developing arrangements and ensure their active involvement.

5. **Independent Scrutiny**:
    - Safeguarding partners must establish effective independent scrutiny to evaluate the effectiveness of MASAs, ensure statutory duties are fulfilled, and provide constructive challenge.
6. **Funding**:
    - Safeguarding partners must agree on equitable funding contributions to support MASAs, including business support, training, and local child safeguarding practice reviews.
7. **Reporting**:
    - Safeguarding partners must publish their arrangements and provide a **yearly report** on the impact and effectiveness of MASAs. Reports should include evidence of progress, learning from reviews, and contributions from relevant agencies.
8. **Dispute Resolution**:
    - Safeguarding partners must establish a system to resolve disputes locally. If unresolved, issues may be escalated to the Secretary of State.

Key Objectives:

- Ensure clear roles and responsibilities for all involved.
- Promote timely information sharing and decision-making.
- Use data and intelligence to identify risks and improve outcomes.
- Embed a learning culture to continuously improve safeguarding practices.

Chapter 2 emphasizes the need for strong leadership, collaboration, and accountability to create effective safeguarding arrangements that protect children and promote their welfare.

Chapter 3: Providing Help, Support, and Protection

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Chapter 3 focuses on how agencies, organizations, and individuals work together to provide **help, support, and protection** to children and families. It introduces the concept of **Family Help**, which aims to provide early, targeted, and statutory support to improve outcomes for children and families. It includes National Multiagency standards for child protection in pages 89-91 (see appendix1).

Key Components:

1. **Family Help**:
    - A voluntary, multi-disciplinary approach to address specific concerns within families.
    - Combines targeted early help and statutory services under **Section 17 of the Children Act 1989** (children in need) and **Section 47 of the Children Act 1989** (child protection inquiries).
    - Focuses on building consistent relationships, effective assessment, and clear interventions.
2. **Local Criteria for Support**:
    - Safeguarding partners must agree on criteria for different levels of assessment and services, ensuring children receive the right help at the right time.
    - A **threshold document** should outline processes for accessing universal services, Family Help, and statutory services.
3. **Universal Services and Community-Based Early Help**:
    - Universal services (e.g., education, health, youth services) provide general support to improve family resilience and prevent problems from worsening.
    - **Best Start Family Hubs** play a key role in connecting families to services from pregnancy to age 19 (or 25 for children with SEND).
4. **Role of Education Providers**:
    - Schools, colleges, and early education settings are critical in identifying concerns and providing early support.

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- They must work closely with safeguarding partners to share information and address risks such as persistent school absences, neglect, or exploitation.

5. **Family Help Assessment**:
    - A multi-disciplinary assessment is conducted for families with multiple or complex needs.
    - The assessment considers the needs of all family members, the child's wishes, and the family's circumstances.
    - Lead practitioners coordinate support and services, ensuring the Family Help plan is co-produced with the family.
6. **Safeguarding and Promoting Welfare**:
    - Local authorities have statutory duties under **Section 17** and **Section 47** of the Children Act 1989 to support children in need and protect those at risk of significant harm.
    - Assessments should be child-centered, holistic, and responsive to the needs of the child and family.
7. **Special Considerations**:
    - Support for vulnerable groups such as babies, disabled children, young carers, children suffering harm outside the home, and children in secure youth establishments.
    - The **National Referral Mechanism** is used to identify and support victims of modern slavery and human trafficking.
8. **Child Protection**:
    - Multi-agency child protection arrangements are essential for children suffering or likely to suffer significant harm.
    - Child protection activities should be led by experienced social workers and supported by multi-agency practitioners.

Key Objectives:

- Provide timely and flexible support to families at the point of need.

- Align targeted early help and statutory services to create a seamless system of Family Help.
- Ensure assessments and interventions are child-centered, holistic, and responsive to changing needs.
- Promote collaboration across agencies to safeguard children and improve outcomes.

Chapter 3 emphasizes the importance of early intervention, effective assessments, and coordinated support to help children and families overcome challenges and ensure their safety and well-being. It also provides summaries (pg92-109) of the processes for children when they are referred into the child protection system as well as flow charts (pg110-113) of the same processes.

Chapter 4: Organisational Responsibilities

Chapter 4 outlines the **statutory duties and responsibilities** of individual organizations and agencies in safeguarding and promoting the welfare of children. It emphasizes the importance of clear accountability, effective policies, and collaboration across sectors.

Key Components:

1. **Section 11 Duties** (2004 Children Act):
    - Places legal obligations on organizations such as local authorities, NHS bodies, police, probation services, prisons, youth offending teams, and others to ensure their functions are discharged with regard to safeguarding children.
    - Requires clear accountability, senior leadership, whistleblowing procedures, escalation policies, safe recruitment practices, and safeguarding training.
2. **People in Positions of Trust**:
    - Organizations must have policies to address allegations against individuals working with children, including clear processes for investigation and support.
    - Local authorities must designate a **Local Authority Designated Officer (LADO)** to oversee allegations against adults working with children.

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3. **Individual Organizational Responsibilities**:
    - **Schools, Colleges, and Education Providers**: Must follow statutory guidance such as *Keeping Children Safe in Education* and have safeguarding policies, designated safeguarding leads, and training for staff.
    - **Early Years and Childcare Providers**: Must comply with the Early Years Foundation Stage (EYFS) framework, have safeguarding policies, and appoint a designated safeguarding lead.
    - **Health Services**: NHS organizations must ensure safeguarding arrangements are in place, including designated and named health professionals to provide advice, training, and leadership.
    - **Police**: Police officers must identify risks to children, share information, and use statutory powers (e.g., Section 46 of the Children Act 1989) to protect children in emergencies.
    - **Adult Social Care Services**: Must consider the needs of children when working with adults, especially in cases involving mental health issues, substance misuse, or domestic abuse.
    - **Housing Services**: Must address housing conditions that impact children's welfare and work with social care to prevent homelessness.
    - **Probation Service**: Responsible for assessing risks posed by offenders to children and sharing information with children's social care.
    - **Youth Offending Teams (YOTs)**: Supervise children subject to pre-court interventions and statutory court disposals, identifying risks and protecting children from harm.
    - **Prison Service**: Responsible for safeguarding children impacted by parental imprisonment and managing risks posed by prisoners to children.
    - **Mother and Baby Units in Prisons**: Ensure the welfare of children living with their mothers in prison.
    - **British Transport Police**: Safeguard children on the rail network, especially those who are missing, exploited, or at risk of harm.

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- **Channel Panels**: Provide support to children vulnerable to radicalization under the Prevent Duty.

4. **Voluntary, Charity, Faith-Based, and Private Sector Organizations**:
   - These organizations play a vital role in safeguarding children and must have appropriate policies and procedures in place.
   - They should collaborate with safeguarding partners and ensure staff and volunteers are trained in safeguarding responsibilities.
5. **Sports Clubs and Organizations**:
   - Sports clubs must have safeguarding arrangements and work with safeguarding partners to protect children.
   - National Governing Bodies of Sport receiving funding from Sport England or UK Sport should meet the *Standards for Safeguarding and Protecting Children in Sport*.

Key Objectives:

- Ensure all organizations and agencies have robust safeguarding policies and procedures.
- Promote collaboration and information sharing across sectors.
- Provide clear accountability and leadership for safeguarding children.
- Support children and families through coordinated efforts across all relevant organizations.

Chapter 4 emphasizes the shared responsibility of all organizations and agencies to safeguard children, with a focus on accountability, collaboration, and compliance with statutory duties.

Summary of Chapter 5: Learning from Serious Child Safeguarding Incidents

Chapter 5 outlines the **process for learning from serious child safeguarding incidents** to improve practices and prevent future harm. It emphasizes the importance of timely notifications, reviews, and collaboration between safeguarding partners and the **Child Safeguarding Practice Review Panel**.

Key Components:

1. **Serious Incident Notification**:

- Local authorities must notify the **Child Safeguarding Practice Review Panel** within **five working days** of becoming aware of a serious incident involving a child.
- Serious incidents include cases where a child has died or suffered serious harm due to abuse or neglect, either within the local authority area or while normally residing there.
- Notifications must be accurate, comprehensive, and include all children involved in the incident.

2. **Rapid Review**:
   - Safeguarding partners must conduct a **rapid review** within **15 working days** of the notification.
   - The review aims to gather facts, identify immediate actions, and determine whether a **Local Child Safeguarding Practice Review (LCSPR)** or a **national review** is needed.
   - The rapid review findings are shared with the Panel, which may recommend further action.
3. **Local Child Safeguarding Practice Review (LCSPR)**:
   - Safeguarding partners decide whether a serious incident warrants an LCSPR based on criteria such as:
     - Potential improvements to safeguarding practices.
     - Recurrent themes in child welfare.
     - Concerns about multi-agency collaboration.
   - LCSPRs should be completed within **six months** of the decision to initiate the review.
   - The review should focus on learning, not assigning blame, and involve practitioners, children, and families.
4. **Publishing LCSPR Reports**:
   - Safeguarding partners must publish LCSPR reports unless it is deemed inappropriate to do so.

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- Reports should include recommended improvements, systemic issues, and actions to prevent future harm.
- Reports must be publicly available for at least **one year** and shared with the Panel, the Secretary of State, Ofsted, and other relevant bodies.

5. **National Reviews**:
   - The Panel may commission **national reviews** for cases of complex or national importance, such as those involving institutional settings, multiple types of abuse, or legislative concerns.
   - National reviews should be completed and published within **six months** of the decision to initiate the review.
   - The Panel must ensure the findings are widely disseminated to improve safeguarding practices across the country.
6. **Learning and Improvement**:
   - Safeguarding partners must use findings from local and national reviews to improve practices and outcomes for children.
   - Learning should be reflected in **yearly reports** and monitored to ensure sustained improvements.

Key Objectives:

- Ensure timely and accurate notifications of serious incidents.
- Conduct reviews to identify systemic issues and areas for improvement.
- Promote transparency and accountability through published reports.
- Use findings to drive local and national improvements in safeguarding practices.

Chapter 5 highlights the importance of learning from serious incidents to improve safeguarding systems, prevent future harm, and ensure better outcomes for children. It emphasizes collaboration, transparency, and a focus on systemic learning rather than individual blame.

Chapter 6: Child Death Reviews

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Chapter 6 outlines what happens as a result of the devastating death of a child in any circumstances. The systematic process of review is grounded in respect for children and their families, with the intention of learning what happened and why, and preventing future child deaths.

- Child death reviews are carried out by child death review partners (local authorities and ICBs).
- The child death review partners follow their statutory responsibilities ensuring that parents and carers are provided with information about what happens when a child dies.
- Child death review partners should set up a panel and a process in line with the statutory guidelines to review child deaths, including appointing a designated doctor for child deaths.
- Other organisations and agencies that have had involvement in the case should co-operate with the panel as appropriate.
- Registrars of Births and Deaths must inform the child death review partners with the particulars of any child who has died.
- Coroners must notify the child death review partners if they decide to investigate an death of a child, including the request for a post mortem.

The chapter also provides a flow chart and a summary of the process that happens when a child dies.

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Appendix 1 National Multi-Agency Practice Standards

These are for all practitioners working in services and settings who come into contact with children who may be suffering or have suffered significant harm inside or outside the home. Section B is specifically targeted at practitioners across agencies directly involved in child protection work.

A: Recognising actual or likely significant harm for all practitioners

• Practitioners are alert to potential indicators of abuse, neglect, and exploitation, and listen carefully to what a child says, how they behave, and observe how they communicate if pre-verbal or non-verbal (due to age, special needs and/or disabilities, or if unwilling to communicate). Practitioners will try to understand the child's personal experiences and observe and record any concerns.

• Practitioners communicate in a way that is appropriate to the child's age, developmental stage and ability, and use evidence-based practice for engaging inclusively with all children, including those with special educational needs and disabilities.

• When practitioners have concerns or information about a child that may indicate a child is suffering or likely to suffer significant harm, they share them with relevant practitioners and escalate them if necessary, using the referral or escalation procedure in place within their local multi-agency safeguarding arrangements. They update colleagues when they receive relevant new information.

• Practitioners should give full consideration to concerns reported by family members, without bias or prejudice. Practitioners should not consider referrals as malicious without undertaking a full and thorough multi-agency assessment.

• Practitioners never assume that information has already been shared by another professional or family member and always remain open to challenging and changing their views about the likelihood of significant harm.

B: Section 47 enquiries, child protection conferences and child protection plans

• Practitioners are aware of the strengths and limitations of their personal expertise and agency remit. They work collaboratively and proactively with multi-

agency practitioners to build an accurate and comprehensive understanding of the daily life of a child and their family to establish the likelihood of significant harm and any ongoing risks. Practitioners respect the opinions, knowledge and skills of multi-agency colleagues and engage constructively in their challenge.

• Practitioners have an applied understanding of what constitutes a child suffering actual or likely significant harm. They consider the severity, duration and frequency of any abuse, degree of threat, coercion, or cruelty, the significance of others in the child's world, including all adults and children in contact with the child (this can include those within the immediate and wider family and those in contexts beyond the family, including online), any risk of harm to others (both children and adults) and the cumulative impact of adverse events.

• Practitioners take care to ensure that children know what is being discussed about them, and their family, where this is appropriate. They ask children what they would like to happen and what they think would help them and their family to reduce the likelihood of significant harm, including where harm is taking place in contexts beyond the family home. Practitioners listen to and act upon what children tell them.

• Practitioners engage parents and the family network, as appropriate, in the discussions, recognising previous involvement with agencies and services may influence how they engage. Practitioners encourage parents and families to express what support would help them to reduce significant harm.

• Practitioners thoroughly explore the significance of the adults in contact with the child and their family or individual histories. They should pay particular attention to any serious criminal convictions, previous allegations of child abuse, domestic abuse or impulsive violent behaviour, restrictions on contact with children or involvement with children subject to child protection plans or care proceedings.

• Practitioners satisfy themselves that conclusions about the likelihood of significant harm give sufficient weight to the views, experiences, and concerns of those who know the child and/or parents well, including relatives who are protective of the child, and other relevant practitioners.

• Practitioners share their thinking and proposed recommendations with other practitioners who hold relevant information and insight into the child and adults

involved with the child. Practitioners comment, challenge, and jointly deliberate, before making a final decision about the likelihood of significant harm.

• Together with other agencies, practitioners clarify what family help and multi-agency action is necessary to reduce the likelihood of significant harm and maintain reasonable care for the children. They seek assurance that this resource is available and of sufficient expertise, skill and intensity. There should be continuity of multi-agency, multi-disciplinary engagement and expertise throughout child protection activity.

• Where significant harm is outside the home, practitioners work collaboratively with children, parents and carers and community partners, to understand the context in which harm is occurring and to determine the actions that each agency can take to reduce harm.

• Practitioners explain clearly to parents and the family network the implications of the threshold that has been reached for section 47 enquiries, the initial child protection conference, and any ongoing child protection plan (including that this threshold may lead to pre-proceedings, should the likelihood of significant harm not reduce). Practitioners do everything they can to ensure that parents and the family network understand and can engage purposefully with the enquiries and any protection plan.

• Practitioners remain alert to changes in circumstances for the child and family and respond as new information comes to light that needs to be reflected in the child protection plan.

• Practitioners reflect on the proposed protection plan and consider adjustments to strengthen the protection plan. The protection plan is specific, achievable, and relevant to the likelihood of significant harm and the context in which it is occurring.

• Interventions are prompt, evidence-based and address the child's needs, proactively tackling and reducing harm.

C: Discharging the child protection plan

• Practitioners work as part of a multi-agency team to create lasting change for families and ensure the child, parents and family network know that further help and support is available if needed or further concerns arise.

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• Following a decision to discharge a child protection plan, practitioners ensure that appropriate support is in place for the child and family and respond to changing circumstances and new information.

• Where a child becomes looked after, practitioners ensure that this is well planned and that the child, parents and family network are appropriately supported. Ongoing need is monitored as part of care planning.

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