# LONDON BOROUGH OF HAVERING MASH PROTOCOLS

Havering
LONDON BOROUGH

Updated June 2023

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## BACKGROUND

Section 10 of the Children Act 2004 created a requirement for Children's Services to make suitable arrangements for co-operation between the relevant partners in order to improve the wellbeing of children in the authority's area. Statutory guidance for Section 10 of the Act states; *"good information sharing is key to successful collaborative working and arrangements should ensure information is shared for strategic planning purposes and to support effective service delivery."* The London Child Protection procedures provides safe and effective processes to enable us to deliver on our statutory duties.

The main aim of a Multi-Agency Safeguarding Hub (MASH) is to improve the quality of information sharing and decision making between agencies, at the earliest opportunity. This is historically an area for improvement in multi-agency child protection work and is consistently cited as a factor in serious case reviews and high level child protection inquiries.

A MASH team comprises of a group of practitioners, still employed by their individual agencies (local authority, police, probation, health services, housing etc.) but co-located in one office. It operates on the basis of a 'sealed' intelligence hub, with clear information sharing protocols, giving partners the confidence and trust to engage fully in effective multi-agency working. By combining the information held by the full range of agencies working with a child or family, the MASH process allows practitioners to build up a fuller picture of an individual child's circumstances and history before deciding the most appropriate course of action to keep them safe.

The MASH process was strongly endorsed by the Ofsted report, 'Good Practice by Local Safeguarding Children Boards' and 'The Munro Review of Child Protection'.

Five factors have been identified as core components which every MASH will need in order to work effectively:

- **All notifications relating to safeguarding and promoting the welfare of children to go through the hub**

All concerns regardless of level must be routed through the hub to ensure that low level repeat concerns from a variety of partners can be identified in the MASH, preventing these from being masked through volume or lost in the bureaucracy of a partnership. This focuses on anything with regard to safeguarding and promoting the welfare of children, and will enable effective interventions at the earliest opportunity. Having one route in and one decision making process ensures a standard of risk assessment and decision making that can be consistent, clear and transparent that can be audited effectively.

- **Co-location of professionals from core agencies to research, interpret and determine what is proportionate and relevant to share**

This is critical to ensuring all partners have the confidence and trust to engage fully in effective working. The duty of care for agency information remains with the 'owner' at all times, and the

decisions to share information are made on a case-by-case basis within the statutory framework to ensure information is available upon which to make the best decision. All information should be disclosed within the security of the hub.

- **The MASH activity is confidential and separate from operational activity and provides an appropriate confidential record sharing system of activity to support this**

This provision is required to ensure sensitive information remain in a confidential environment, where only those who need to know get to see the information. Information is disclosed on a strictly 'need to know basis' in line with GDPR and Children's legislation. .

- **An agreed process for analysing and assessing risk, based on the fullest information picture and dissemination of a suitable information product to the most appropriate agency for necessary action**

Essentially, this is a partnership giving itself the best opportunity to make effective and efficient decisions through having the most complete up to date information at the earliest stage. By utilising a standardised risk assessment and threshold model, a consistency and clarity of decision making will be achieved. The MASH will provide proportionate and relevant information to appropriate agencies.

- **A process to identify victims and emerging harm through research and analysis**

The MASH provides a secure environment where information is subjected to ongoing research and analysis. This will identify victims and perpetrators by understanding repeat notifications and the identification of individuals who may suffer increasing levels of harm in the future. The identification of these individuals and the families around them will enable services to intervene at a much earlier time, thereby providing opportunities to reduce harm and long term impact and costs. The provision of analysis within the MASH enables the commissioning and prioritisation of resources to improve safeguarding provision and meet identified needs.

## INTRODUCTION

This document is intended for use by all staff working in the MASH. It should be read used in conjunction with the London Safeguarding Childrens Board Information Sharing Agreement, Multi-Agency Threshold Document, Pan London Procedures and Havering Children's Social Care Policies & Procedures. This document has been agreed by all MASH partners.

The procedures aim to ensure that managers and staff in the MASH have a clear understanding of the MASH processes and procedures for workflow, information sharing and multi-agency working.

The procedures are to be used as guidance and do not preclude the need for workers to make decisions and use their judgement and professional curiosity.

## INFORMATION SHARING AGREEMENT

**MASH Privacy Notice**

Information sharing in the MASH is determined by the 1989 and 2004 Children Act. The main legal gateway for cases being placed through the MASH is the 1989 Children Act whereby the MASH is used to determine if the Local Authority has a duty to assess (Section 17) if a child is in need and whether there is a statutory need to undertake a child protection investigation (Section 47). The 2004 Children Act, Section 10 and 11 places an obligation on the Local Authority to cooperate with partners such as the police and NHS to promote the welfare of the child.

The following criteria permits the local authority a legal obligation to share information:

- The family has been informed of the referral and the legal basis for placing the case through the MASH
- The family has been signed posted to the Havering Internet to review the MASH privacy notice. (If they do not have access to the internet the MASH will print the privacy document and send it out to the family in the post).
- The family has not been informed that this referral has been placed through the MASH at this stage because the child would be placed at further risk due to the high level referral concerns and the rationale for this decision has been recorded.
- The family has not been informed of the referral being placed through the MASH at this stage because sharing information would prejudice the prevention, detection or prosecution of a serious crime (Including sexual abuse / high level physical abuse / terrorism) and the rationale for this decision has been recorded.
- We have been unable to contact the family due to the non-answer of calls, emails or text messaging. A message is left if appropriate explaining that we have received a referral and requesting a call back.

## MANAGING THE MASH

The MASH is operational between the hours of 9am and 5pm Monday to Friday. Concerns identified outside of these hours should be reported to the Out of Hours Emergency Duty Team (01708 433999)

The MASH managers are responsible for co-ordinating and directing MASH operations and ensuring that MASH team members carry out their respective roles so that the process runs smoothly, and the main objectives of the MASH are met. This includes liaising with the duty Assessment team manager and the Early Help manager on a daily basis to ensure the smooth transition of cases through the MASH. The MASH managers will liaise closely with Police, Health representatives and other relevant partners.

## MANAGEMENT OF CONTACTS

Havering MASH performs the following key functions:

- To act as the single point of entry for referrals regarding the well-being and protection of children, strengthening the safeguarding partnership's ability to meet the needs of children and young people in Havering.
- To receive all safeguarding child contacts
- To provides a consultation line (MASH DUTY LINE) for professionals to speak to a social worker for information, advice and guidance with oversight from a manager.

The MASH receives contacts through a variety of methods including; The Havering MASH Portal, TMASH email box (for Police Merlins, London Ambulance Service, London Fire Brigade or orders from the Courts) or via telephone. These contacts are made by professionals, members of the public and service users.

A contact is the initial request for a service, advice or information.

Contacts from professionals must be made using a multi-agency referral form; which is completed through our online Portal, where there are immediate child protection concerns, referrals must be made by telephone and followed up in writing as soon as possible using the online Portal.

The MASH manager will screen all incoming contacts and prioritise contacts using a RAG rating system (red, amber or green) considering the following to determine the most appropriate pathway:

- Presenting risk, harm and vulnerability
- Known children social care history about the child and family
- Multi-agency threshold document

Any contact can be closed down immediately if it does not meet the threshold for level 2, 3 or 4 interventions. Alternatively, where threshold is clearly met these contacts will be progressed in a timely manner to a referral to the duty assessment team.

The MASH business process essentially has three pathways to identify, prioritise, review and progress contacts as follows:

1. **Triage of high risk contacts.** If contacts are accepted as referrals and RAG rated as red (although this may include some amber ratings) indicating children are at immediate risk of significant harm, the referrals are fast-tracked by the hub as referrals to be picked up by the duty assessment team.

2. **Screening.** Some contacts, mainly those rag rated amber and green although this could include some red, will also follow a screening process. The initial contact is allocated to a social worker in the MASH to speak to the parents, review the history and referral in order to recommend a threshold decision within 24 hours.

3. **Undertaking MASH enquiries** - Where a threshold decision cannot be made at the first stage of screening and more information is required, the contact is moved to second stage called a MASH enquiry requesting contribution from partners to inform decision making in line with the MASH RAG timescales.

## PARTNERSHIP MASH PROCESSES / INTERFACE

In line with policies and legislation the Multi-Agency partnership will:

- Share information that is necessary, proportionate and relevant to assist the MASH process.
- Ensure for all contacts subject to MASH enquiry, relevant partner agencies are responsible to undertake and contribute to the research carried out on the contact within the agreed MASH RAG timescales.
- Ensure each agency completes checks within their own organisations and brings any relevant information to the daily MASH meeting. For contacts that do not reach threshold for statutory intervention, consideration should be given to what information can and should be shared without consent with other agencies. If information is shared the rationale should be recorded.
- Ensure each partner keeps local records so that their organisation is aware of how its information is being used.

All contacts received by the MASH will be subject to three possible phases explained in more detail below in relationship to information sharing and partner input:

1. Identification of child/ family where information is not fully known (demographic check)
2. MASH Partnership Meeting
3. MASH Episode / Enquiries

## IDENTIFICATION OF CHILD/FAMILY WHERE INFORMATION IS NOT FULLY KNOWN (DEMOGRAPHIC CHECK)

In some contact cases, it will be necessary for the MASH social work team to send an email to Housing, Police or Health MASH partners to clarify information such as addresses, and/or telephone numbers. The purpose of the request is to establish and clarify the identity of a child, other details like NHS numbers, siblings in the home etc. The requests are to inform decision making and make contact as necessary. Where requests occurs the rationale for doing so will be recorded.

## DAILY MASH MEETING

Daily MASH meetings take place Monday to Friday in the morning. These meetings are attended by representatives of all core MASH members and chaired by the MASH manager. The purpose of the meeting is:

- To consider new referrals that have come in overnight (Police MERLINS, EDT summaries & hospital notifications)
- To facilitate timely, coordinated and effective face to face joint information-sharing in order to reduce any delay in families receiving a service
- To support robust multi-agency working with good and consistent application of threshold
- To provide an additional layer of scrutiny regarding decision-making and ensuring that all actions are responsive and proportionate to risk
- To facilitate & strengthen the identification of, and provision for, families in need of early help provision (step down)
- To quickly step up cases when concerns for children escalate
- Complete a multi-agency audit

Contacts identified for the MASH meeting will normally have already been given an initial RAG rating of **Amber** by the screening manager before the MASH Meeting. Following review of the contact the MASH members will have an opportunity to make a joint decision to revise the initial rating to a final rating using the threshold document Decisions are based on the information gathered and shared between agencies.

The thresholds for the RAG rating pre-MASH stage are a preliminary assessment of the level of intervention required. At the post-MASH stage the rating sets the level of intervention required based on the information that has been gathered. The second rating is better informed, and therefore, guides the intervention process better.

RAG rating the contact pre and post MASH meeting does two things; firstly it confirms the level of risk deemed to be present for the child and family at the point of initial contact. Secondly it shows whether the initial contact information indicated a lower risk than the risk associated with the "whole picture" for the child provided by information gathered from the MASH. This allows meaningful information-sharing where the risk assessments are dynamic and help staff to determine the best action to take allowing outcome focused decision making. For example, an initial RAG moving from amber to Green based on information held and shared by partner(s) gives a check and balance within the system, providing the opportunity to continually reflect on the level of risk and support to families. All partners need to refer to the London Safeguarding Children Partnership Threshold - Continuum of Need Matrix document (2022) which is readily available.

## DAILY MASH PARTNERSHIP MEETING

The daily MASH meeting will work to the following Agenda:

- Recording of attendance
- Reviewing any outstanding actions from the previous meeting to free/ monitor any blockages
- Review of new cases to seek agreement on outcomes required and final RAG rating
- Identification of any good practice or learning point.

## MASH EPISODE/ENQUIRIES

The MASH enquiry process will be initiated when informed decisions cannot be made at the MASH screening stage 1. Usually this occurs when there are unknown needs, harm and risk factors or where information gaps that have been identified by the assessing social worker or based on other specific criteria as outlined below.

## CRITERIA FOR PROGRESSING TO MASH ENQUIRIES

The following criteria is used to progress contacts and referrals to MASH enquiries (which can be in parallel to the referral to the assessment team process and requests for strategy discussions for red RAG rated concerns):

- All Domestic Abuse referrals where the police are not the referrer and additional information is required to determine the threshold and where the Barnardo's risk matrix is rated as serious level 2 and 3
- All referrals where there is a combination of factors including mental health, drug/alcohol and domestic abuse
- All referrals where the child or adult is presenting with significant mental illness (self-harming, psychosis, depression, etc.). In the case of a child this will be subject to parental consent where appropriate
- All contacts that evidence a child or young person is involved with gangs or being exploited by gangs
- Where there have been frequent referrals (i.e.3 or more in a 6 month period or if the significance warrants further exploration of risk)
- Where there have been frequent referrals raising concerns of neglect (3 or more referrals in a 6 month period)
- All referrals of children / young people at risk of sexual or other criminal exploitation e.g. county lines / modern day slavery
- Any suspicions or allegations of Fabricated Illness
- Any PREVENT referrals / Radicalisation referrals
- Any Modern Day Slavery referrals / trafficking
- Any Serious and Organised Crime referrals
- Where there has been a referral of Class A parental substance misuse
- Where there have been repeat contacts and referrals regarding minor concerns about a child (three contacts)
- Any referral regarding a child found begging
- Any referral in relation to Female Genital Mutilation (FGM) or faith based abuse e.g. breast flattening, forced marriage, honour based violence etc.
- Any repeat missing person referral in line with missing protocol
- Any child under the age of 16 who is pregnant
- Any NSPCC referrals
- Any other referrals deemed appropriate for MASH enquiries by MASH Managers with the rationale for the decision clearly recorded.

At this stage, all core and virtual partners can be engaged and will receive an electronic request initiated by the duty MASH manager as the decision maker with an indicated RAG rating. The request will follow agreed timescales for information gathering, completion and

return to the duty decision maker to make an overall decision regarding the case. Reviews of decisions can be discussed in the daily MASH meeting or as part of regular ongoing audits

## RAG RATING SYSTEM

The RAG ratings are based on the Havering Multi-Agency Threshold Document and the London Child Protection Procedures. The RAG timescales/ priority for processing work are as follows for MASH enquires:

| RAG Rating | Response | MASH Response Time |
|---|---|---|
| Red (Level 4) – Acute / Child Protection: Requires Intensive support as there is "reasonable cause to suspect that a child …. is suffering or likely to suffer significant harm" Children Act 1989 Sec 47 | S47/Child Protection | 4 hrs |
| Amber (Level 3) – Complex / Child in Need: Complex needs that are likely to need longer term intervention from statutory or specialist services. | S17/Child in Need | 24 hrs |
| Green (Level 2) – Vulnerable: Universal support and more targeted support services are needed. | Early Help | 72 hrs |

## FEEDBACK

The duty contact officer in the MASH team is expected to feed back to the referrer within 48 hours of the decision being made on the contact received.

## EVALUATION AND QUALITY ASSURANCE OF THE MASH

Each agency will be responsible for ensuring the timeliness, quality and accuracy of information provided.

Agencies remain responsible for the professional conduct and quality of work of their staff working within the MASH and should take action to address any capability or disciplinary matters.

This protocol and the data sharing protocol will be reviewed annually by the Partners and Safeguarding Partnership.

Quarterly MASH Steering Group meetings are held in line with the MASH Governance Structure to ensure there is partnership engagement, accountability and feedback.

## OPEN CASES

When a Police MERLIN or other referral has been identified on an open case i.e. the child is allocated to a Social Worker; the referral will be sent to the allocated Social Worker or Social Services Team via the MERLIN Notification process. No checks will be completed. The Social Worker in charge of the case can request checks or research via the agreed process i.e. through the completion of an 87B form.

## DOMESTIC ABUSE

Given a high proportion of Police MERLIN's can relate to domestic abuse incidents, many will require an assessment for support and intervention and may need to be referred to the Multi Agency Risk Assessment Conference (MARAC). The MASH decision maker will make recommendation for CADDA RIC assessment to be completed and MARAC referral to be completed if criteria is met.

## MISSING, CSE AND GANG ACTIVITY

In the case of Police Missing reports of children missing from home and care, these will be referred to the MASH enquiry process and may include important information and intelligence sharing provided as a result of Police "safe and well checks". The importance of understanding this information in respect of the child who has gone missing, and more generally in relation to local intelligence can help protect other children, is critical to help inform the local safeguarding partnership's ability to understand and respond to CSE and other forms of exploitation in the borough. Gang activity will also be reported into the MASH via Police "Merlin" reports.

Children and young people will be offered Return home interviews to ensure that information on push/pull and other exploitation factors are identified and responded to in line with the missing protocol.

## MASH ICT ARRANGEMENTS

Each agency within the MASH remains responsible for accessing, scrutinising and reporting on their agencies data, information and intelligence. Although safeguarding partners can ultimately share their agency's information in line with appropriate processes; it is not envisaged that partners will have access to each other's data bases as this is likely to contravene agency data security arrangements. Each MASH partner will make appropriate

arrangements to have access to their own agency's data base within the MASH via an approved IT arrangement.

• CSC– Liquid Logic

• Education Welfare (navigator)

• Police – PND, Visor,

• Health (Rio)

• Probation

Access to the MASH area in Havering is restricted to appropriate personnel to ensure confidentiality of information.

## MASH INFORMATION DATA

MASH performance reports are prepared on a monthly basis by the London Borough of Havering (LBH) Performance Team. The reports have been developed in consultation with the MASH Steering Group, which meets on a quarterly basis to review reports and performance. The MASH report includes the following summaries:

- Contact source
- Timeliness of contacts
- Timeliness of MASH episodes
- How many MASH enquiries were stepped across to early help
- How many contacts progress for a statutory assessment
- How many MASH enquiries were signposted or required No Further action (NFA)

## MASH INFORMATION SHARING AGREEMENT

An updated and revised version of the Information Sharing Agreement (ISA) has been drafted and agreed by all local safeguarding partners at the MASH Steering Group to ensure compliance with policies and legislation.

## RESOLVING DISAGREEMENTS

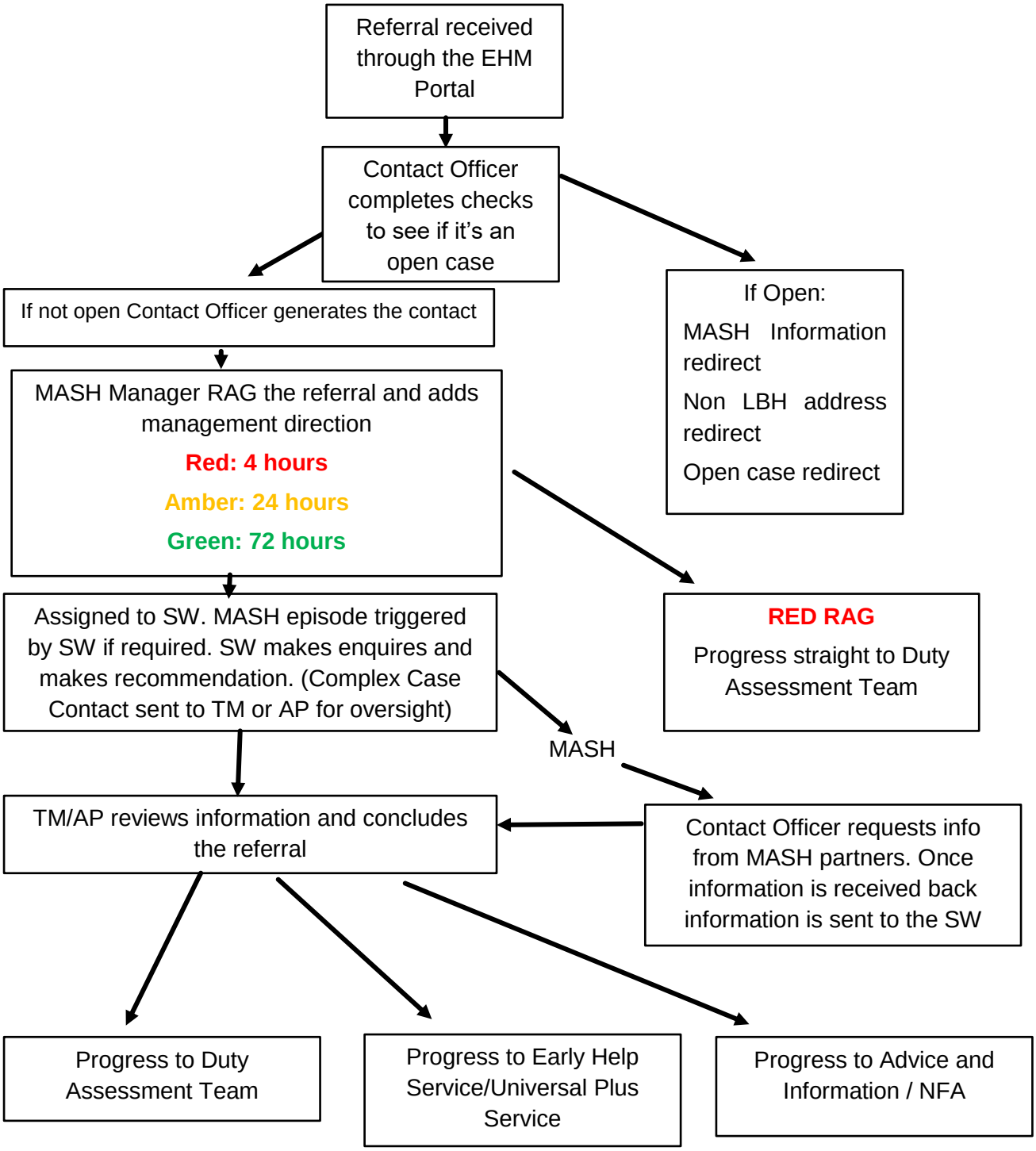
In the event of any disagreements arising between partner agencies relating to MASH operations or decision-making, this will be dealt with in the first instance at local level through discussion with partner team members.

Where a resolution cannot be found at this level within a reasonable timescale, the matter should be referred to the Strategic Head of Service responsible for the MASH service, who may raise the issue with senior staff within the MASH partner agencies in order to find a solution. If issues cannot be resolved at that level, they will be taken to the Havering Safeguarding Children Partnership.

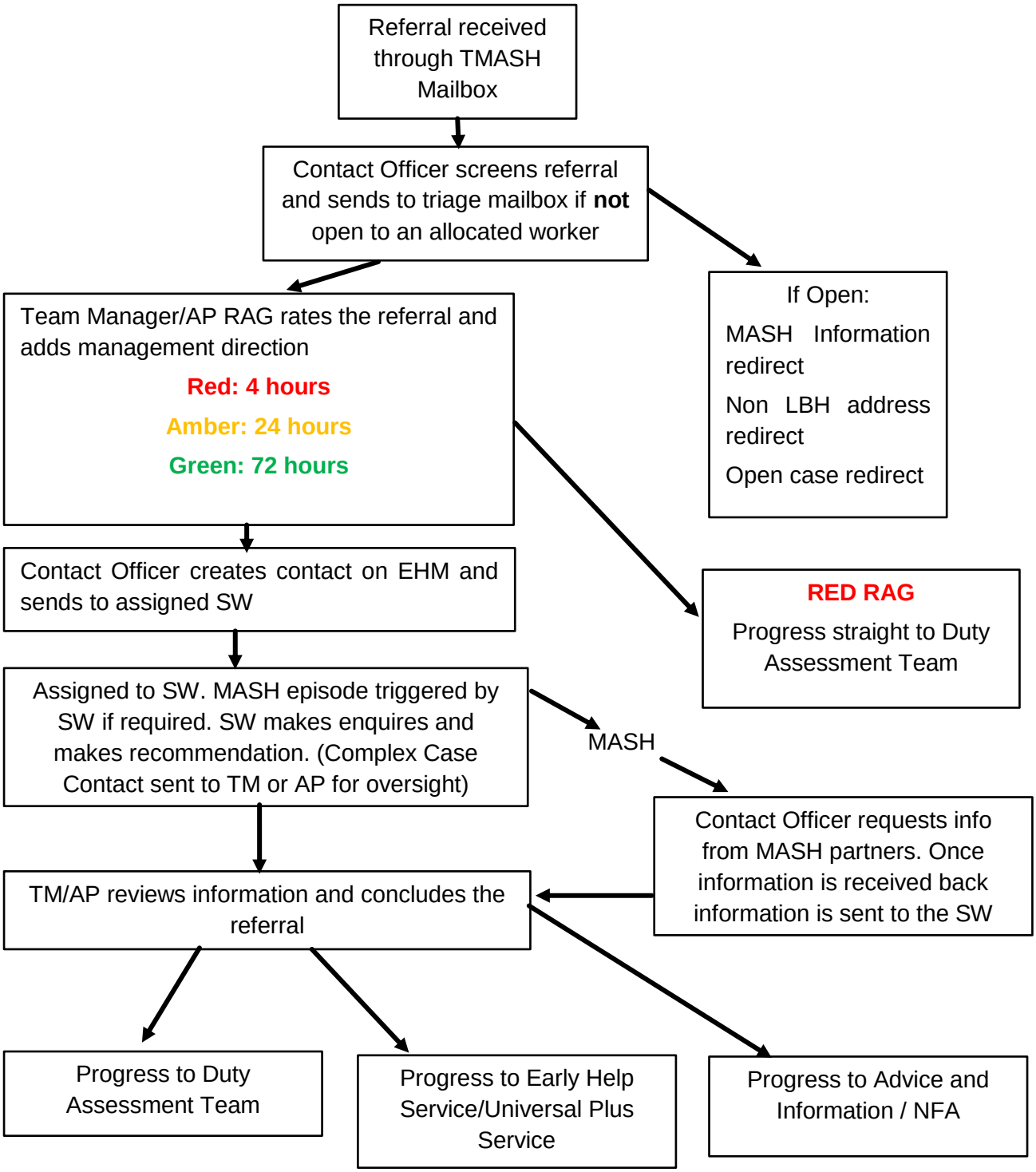
## MASH GOVERNANCE ARRANGEMENTS

Individual safeguarding partners col-located and engaged in the MASH partnership continue to be responsible for their own line management and supervision. However, in recognition of the importance and necessity of working well together; a MASH Operational Strategic Group will continue to meet on a three monthly basis to plan, monitor and review the collective day to day operational practice within the MASH.

## MASH REFERRAL PROCESS PORTAL



## MASH REFERRAL PROCESS – MERLINS, LAS, FIRE AND COURT



## MASH PRIVACY NOTICE

**Information Sharing**

Information sharing in the MASH is determined by the 1989 and 2004 Children Act. The 1989 Children Act gives a legal gateway to the MASH to consider and determine if the Local Authority has a duty under Section 17 of the Act to assess if a child is in need and / or whether there is a statutory need to undertake a child protection investigation under Section 47. Section 10 and 11 of the 2004 Children Act, places an obligation on the Local Authority to cooperate with partner such as the police and NHS to promote the welfare of the child.

Please refer to page 5 of this document for additional detail on Information Sharing under Privacy Notice.

## CONTINUUM OF NEED MATRIX – THRESHOLD DOCUMENT

In order for professionals to make good decisions about children in need of help and protection, they have to have a full picture of what is happening in a child's life. In order to do this it is important for professionals to have access to all the information known about the child. But just as important is seeking out missing information, considering disparate pieces of information to build an understanding, and asking what bigger picture is being painted about a child's experience. In child protection, abuse and neglect' rarely presents with a clear, unequivocal picture. It is often the totality of information and the overall pattern of the child's story, which raises professionals' suspicions of possible abuse or neglect.

| HEALTH | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| The child appears healthy, and has access to and makes use of appropriate health and health advice services | The child rarely accesses appropriate health and health advice services, missing immunisations. | There is no evidence that the child has accessed health and health advice services and suffers chronic and recurrent health problems as a result. Diagnosed with a life-limiting illness. | The child has complex health problems which are attributable to the lack of access to health services. Carer denying professional staff access to the child. |
| All child's health needs are met by parents. | Additional help required to meet health demands of the child including disability or long term serious illness requiring support services. | With additional support, parent not meeting needs of child's health. Carer displays high levels of anxiety regarding child's health. | Carers' level of anxiety regarding their child's health is significantly harming the child's development. Strong suspicions / evidence of fabricating or inducing illness in their child |
| Carer does not have any additional needs | Needs of the carers are affecting the care and development of the child | Needs of the carer / other family members significantly affect the care of child | |
| Parent accesses ante-natal and/or post-natal care | The carer demonstrates ambivalence to ante-natal and post-natal care with irregular attendance and missed appointments. | The carer is not accessing ante-natal and/ or post-natal care, significant concern about prospective parenting ability, resulting in the need for a pre-birth assessment. | The carer neglects to access ante-natal care and there are accumulative risk indicators |
| The parent is coping well emotionally following the birth of their baby and accessing universal support services where required. | The parent is struggling to adjust to the role of parenthood, post-natal depression is affecting parenting ability. | The parent is suffering from post-natal depression. Infant / child appears to have poor growth - Growth falling 2 centile ranges or more, without an apparent health problem. New-born affected by maternal substance misuse. | The carer is suffering from severe post-natal depression which is causing serious risk to themselves and their child/ children. |
| Pregnancy with no apparent safeguarding concerns | Pregnancy in a young person / vulnerable adult who is deemed in need of support. | LAC or Care Leaver or vulnerable young person who is pregnant. | Pregnancy in a child under 13 or parent with significant learning needs. Young inexperienced parents with additional concerns that could place the unborn child at risk of significant harm. |

| MENTAL / EMOTIONAL HEALTH | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| The child is provided with an emotionally warm, supportive relationship and stable family environment providing consistent boundaries and guidance, meeting developmental | Parenting often lacks emotional warmth and/or can be overly critical and/or inconsistent, occasional relationship difficulties impacting on the child's development. Struggles with setting age appropriate | Carers inability to engage emotionally with child leads to developmental milestones not met. Family environment is volatile and unstable resulting in a negative impact on the child, leading to possible vulnerabilities | Relationships between the child and carer have broken down to the extent that the child is at risk of significant harm / frequently exposed to dangerous situations and development significantly impaired. Child has suffered |

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|---|---|---|---|
| milestones to the best of their abilities. | boundaries, occasionally not meeting developmental milestones and occasionally prioritises their own needs before child's | and exploitative relationships, parent/ carer unable to judge dangerous situations / set appropriate boundaries. Allegations parents making verbal threats to children. Child rarely comforted when distressed / under significant pressure to achieve / aspire. | long term neglect due to lack of emotional support from parents. |
| Child has good mental health and psychological wellbeing. | The child has a mild a mental health condition which affects their everyday functioning but can be managed in mainstream schools and parents are engaged with school /health services including accessing remote support services to address this. Child is accessing social media sites related to self-harm, has expressed thoughts of self-harm but no evidence of self-harm incidences.<br>History of mental health condition but have been assessed and discharged home with safety plan and follow up. | The child has a mental health condition which significantly affects their everyday functioning and requires specialist intervention in the community. Parent is not presenting child for treatment increasing risk of mental health deterioration problems as a result No evidence child has accessed mental health advice services and suffers recurrent mental health problems as a result.<br>Child is known to be accessing harmful social media sites to facilitate self-harming. Child self-harms causing minor injury and parent responds appropriately.<br>Child has expressed suicidal ideation with no known plan of intent.<br>Child is under the care of hospital engaging with mental health services. | Child expressed suicidal ideation with intent or psychotic episode or other significant mental health symptoms. Refuses medical care or is in hospital following episode of self-harm or suicide attempt or significant mental health issues. Carer unable to manage child's behaviours related to their mental health increasing the risk of the child suffering significant harm.<br>Child or young person has ongoing suicidal ideation following attempt or is in hospital following episode of self-harm or suicide attempt. |
| The child engages in age appropriate activities and displays age appropriate behaviours, having a positive sense of self and abilities reducing the risk of those wanting to exploit them. | Child has a negative sense of self and abilities, suffering with low self-esteem and confidence making them vulnerable to those who wish to exploit them resulting in becoming involved in negative behaviour/activities. | Child has a negative sense of self and abilities, suffering with low self-esteem and confidence which results in child becoming involved in negative behaviour / activities by those exploiting / grooming them. | Evidence of exploitation linked to child's vulnerability. Child frequently exhibits negative behaviour / activities that place self or others at imminent risk. |
| Mental health of the carer does not affect / impact care of the child. | Sporadic / low level mental health of carer impacts care of child, however, protective factors in place | Mental health needs of the carer (subject to a section under MHA) is impacting on the care of their child and there are no supportive networks and extended family to prevent harm. Carer has expressed suicidal ideation with no known plan of intent. | Mental health needs of the carer significantly impacting the care of their child placing them at risk of significant harm. Carer has ongoing suicidal ideation following attempt or is in hospital following episode of self-harm or suicide attempt |
| Child has not suffered the loss of a close family member or friend | Child has suffered a bereavement recently or in the past and is distressed but receives support from family and friends and appears to be coping reasonably well – would benefit from short term additional support from early help services. | Child has suffered bereavement recently or in the past and recent there has been a deterioration in their behaviour. Low level support has not assisted, long term intervention required. | Child has suffered bereavement and is missing, self-harming, disclosing suicidal thoughts, risk of exploitation, and involvement in gang/criminal activity. |
| LA notified the child is privately fostered by adults who are able to provide for | | Some concern about the private fostering arrangements in place for the child, there may be | There is concern that the child is a victim of exploitation, domestic slavery, or being physically |

| | | | |
|---|---|---|---|
| his/her needs and there are no safeguarding concerns. | | issues around the carers' treatment of the child. The local authority hasn't been notified of the private fostering arrangement. | abused in their private foster placement |

| EDUCATION | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Child is in education/training with no barriers to learning. Planned progressions beyond school/college. Behaviour issues are managed by the school. | Child experiences frequent moves between schools or professional concerns re home education. Reports of bullying but responded to appropriately. Peer concerns managed by the school. | Child's attendance is varied with missing absences and exclusions. Recurring issues raised about child's home education. Inappropriate behaviour from carer/school has not been managed. | Child's achievement is seriously impacted by lack of education. Regular breakdown of school placements. Lack of trust in education system (young person or parents/carers). Repeated concerns about school's management of behaviour |
| Developmental milestones met. | Some developmental milestones are not being met which will be supported by universal services. | Some developmental milestones are not being met which will require support of targeted/specialist services | Developmental milestones are significantly delayed or impaired causing concerns regarding ongoing neglect. (not in the case of those with a disability) |
| The child possesses age-appropriate ability to understand and organise information and solve problems, and makes adequate academic progress | The child's ability to understand and organise information and solve problems is impaired and the child is under-achieving or is making no academic progress | The child's ability to understand and organise information and solve problems is very significantly impaired and the child is seriously under-achieving or is making no academic progress despite learning support strategies over a period of time. | The child's inability to understand and organise information and solve problems is adversely impacting on all areas of his/her development creating risk of significant harm, concerns of carer neglect. |
| The carer positively supports learning and aspirations and engages with school | The carer is not engaged in supporting learning aspirations and/or is not engaging with the school. | The carer does not engage with the school and actively resists suggestions of supportive interventions. | The carer actively discourages or prevents the child from learning or engaging with the school |

| ABUSE AND NEGLECT | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Carer protects their family from danger/ significant harm. | Carer on occasion does not protect their family which if unaddressed could lead to risk or danger | Carer frequently neglects/is unable to protect their family from danger/significant harm. Parents or carers persistently avoid contact / do not engage with childcare professionals. | Carer is unable to protect their child from harm, placing their child at significant risk. Allegations of harm by a person in a position of trust. |
| Child shows no physical symptoms which could be attributed to neglect | Child occasionally shows physical symptoms which could indicate neglect. | Child consistently shows physical symptoms which clearly indicate neglect. | Child shows physical signs of neglect which are attributable to the care provided by their carers |
| Child has injuries which are consistent with normal childish play and activities. | Child has occasional, less common injuries which are consistent with the parents' account of accidental injury - carers seek out or accept advice on how to avoid accidental injury. | Child has injuries which are accounted for but are more frequent than would be expected for a child of a similar age/needs. Carer does not know how injuries occurred or explanation unclear. | Any allegations of abuse or neglect or any injury suspected to be non-accidental injury to a child. Repeated allegations or reasonable suspicion of non-accidental injury. Any allegation of abuse/suspicious injury in a pre-mobile or non-mobile child. Child has injuries more frequently which are not accounted and the child makes disclosure and implicates parents or older family members. |

| | | | |
|---|---|---|---|
| Carer does not physically harm their child including physical chastisement. | Carer uses physical assault (no injuries) as discipline but is willing to access professional support to help them manage the child's behaviour | Carer uses physical assault (injuries) as discipline but is willing to access professional support to help them manage the child's behaviour. | Carer uses an implement causing significant physical harm to a child |
| No concerns re conflict / tensions within the family. | Concerns re ongoing conflict between family and child. | Family is experiencing a crisis likely to result in the breakdown of care arrangements - no longer want to care for child | Family have rejected / abandoned / evicted child. Child has no available parent and the child is vulnerable to significant harm. Child not living with a family member |
| No concerns of inappropriate self-sufficiency | Pattern emerging of self-sufficiency which is not proportionate to a child/young person's age and stage of development | High level of self-sufficiency is observed in a child/young person that is not proportionate to a child/young person's age and stage of development. | Inappropriate, high level of self-sufficiency for child/young person's age and stage of development resulting in neglect. |
| No concerns of fabricated or induced illness. | Child has an increased level of illnesses with the causes unknown | Suspicion child has suffered or is at risk of fabricated or induced illness. | Medical confirmation that a child has suffered significant harm due to fabricated or induced illness |

| **SEXUAL ABUSE / ACTIVITY** | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Nothing to indicate child is being sexually abused by their carer | Concerns relating to inappropriate sexual behaviour / abuse within the family / network but does not amount to a criminal offence. | Allegation of non-recent sexual abuse but no longer in contact with perpetrator. | Concerns re possible inappropriate sexual behaviour from carer / carer sexually abuses their child. Offender who has risk to children status is in contact with Family. Child who lives in a household into which a registered sex offender or convicted violent offender subject to MAPPA moves. |
| Good knowledge of healthy relationships and sexual health | Emerging concerns of possible age appropriate sexual activity of a child. | Suspicions of peer on peer sexual activity in a child over 13 years old. Child under 16 is accessing sexual health and contraceptive services | Suspicions of sexual abuse / sexually activity of a child. Direct allegation of sexual abuse/assault by child and belief that child is in imminent danger and in need of immediate protection |
| Good knowledge of healthy relationships and sexual health. | Single instance of sexually inappropriate behaviour. | Send/receive inappropriate sexual material produced by themselves or other young people via digital or social media, considered as peer-on-peer abuse. Evidence of concerning sexual behaviour – accessing violent / exploitative pornography. | Child is exhibiting harmful, sexual behaviour. Early teen pregnancy. Risk taking sexual activity. |
| Good knowledge of healthy relationships and sexual health. | Age appropriate attendance at sexual health clinic. | Sexually transmitted infections (STI's). Consent issues may be unclear. Verbal or non-contact sexualised behaviour. Historic referrals in regard concerning sexual behaviour | Multiple / untreated sexually transmitted infections (STI's). Concerning sexual activity (behaviour that is upsetting to others). Allegations of non-penetrative abuse. Harmful sexual behaviour. Child exploited to recruit others into sexual activity. Repeated pregnancy, miscarriages and/or terminations. Increase in severity of concerning sexual behaviour. |

| POLICE ATTENTION | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| There is no history of criminal offences within the family. | History of criminal activity within the family including gang involvement, child has from time to time been involved in anti-social behaviour. | Family member has a criminal record relating to serious or violent crime, known gang involvement, child is involved in anti-social behaviour and may be at risk of gang involvement, early support not having the desired impact. Starting to commit offences/re-offend or be a victim of crime. | Re-occurring / frequent attendances by the police to the family home. Family member within household's criminal activity significantly impacting on the child, child is currently involved in persistent or serious criminal activity and /or is known to be engaging in gang activities leading to injury caused by a weapon |
| Young person has no involvement with crime or anti-social behaviour. | Child is vulnerable and at potential risk of being targeted and/or groomed for criminal exploitation, gang activity or other criminal groups/associations. | Child appears to be actively targeted/coerced with the intention of exploiting the child for criminal gain. | Child habitually entrenched / actively criminally exploited. There is a risk of imminent significant harm to the child as a result of their criminal associations and activities. They may not recognise they are being exploited and/or are in denial about the nature of their abuse. |
| Young person has no involvement with crime or anti-social behaviour. | Attention of ASB team or police. Talks about carrying a weapon. Reports from others that involved in named gang. Glamorises criminal or violent behaviour. | Arrested for possession of offensive weapon, drugs, multiple thefts / going equipped / motoring offences. Non-compliance of conditions. | Charged or convicted of Aggravated Robbery/Use of offensive weapon/ possession of large quantities of Class A drugs. Intentional harm of others / animals. |
| Young person has been stopped but not searched. Young person has been stopped and searched with no obvious safeguarding concerns or criminality. | Young person has been stopped and searched in circumstances that cause concern such as time of day and others present but no previous concerns. | Young person regularly stopped and searched indicating vulnerability, exploitation or criminality. Young person arrested as a result of a stop and search. | Young person consistently stopped and searched with risk factors suggested they are being exploited |

| HARMFUL PRACTICES | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| There is no concern the child may be subject to harmful traditional practices. | Concern the child is in a culture where harmful practices are known to have been performed however parents are opposed to the practices in respect of their children. | Concern the child may be subject to harmful traditional practices | Evidence the child may be subject to harmful traditional practices. |
| There are no concerns that the child is at risk of Honour Based Violence. | There are concerns that a child may be subjected to Honour Based Violence. | There is evidence to indicate the child is at risk of Honour Based Violence. | There is specific evidence to indicate a child has been subjected to Honour Based Violence or the child has reported they have been subjected to Honour Based Violence. |
| There are no concerns that the child is at risk of Female Genital Mutilation. | History of practising Female Genital Mutilation within the family including female child is born to a woman who has undergone Female Genital Mutilation, older sibling/cousin who has undergone Female Genital Mutilation. Family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children. Female child where Female | Any female child born/unborn to a mother who has had Female Genital Mutilation and is from a prevalent country, family believe Female Genital Mutilation is integral to cultural or religious identity. Female child talks about a long holiday / confirmed travel to her country of origin or another country where the practice is prevalent. Female child or parent from | Reports that female child has had Female Genital Mutilation/ child requests help as suspects she is at risk of Female Genital Mutilation. Upon return from country where practice is prevalent, noticeable changes in child – dress code, excusing from PE, discomfort in walking, frequenting toilet facilities. |

| | | | |
|---|---|---|---|
| | Genital Mutilation is known to be practiced is missing from education for a period without school's approval. | household where Female Genital Mutilation is known or suspected to have previously been a factor state that they or a relative will go out of the country for a prolonged period with female child. | |
| There are no concerns a child is at risk of Forced Marriage. | | There are concerns that a child may be subjected to Forced Marriage. | Evidence child may be subject to forced marriage or has been subjected to Forced Marriage |
| There are no concerns that the child is at risk of witchcraft. | Suspicion child is exposed to issues of spirit possession or witchcraft. | Evidence child is exposed to issues of spirit possession or witchcraft. | Disclosure from child about spirit possession or witchcraft, parental view that child is believed to be possessed. |

| **EXTREMISM & RADICALISATION** | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Child and family's activities are legal with no links to proscribed organisations | Child makes reference to own and family ideologies. | The child expresses sympathy for ideologies closely linked to violent extremism but is open to other views or loses interest quickly. Child and family have indirect links to proscribed organisations. | The child expresses beliefs that extreme violence should be used against people who disrespect their beliefs and values. The child supports people travelling to conflict zones for extremist/ violent purposes or with intent to join terrorist groups The child expresses a generalised nonspecific intent to go themselves. Child, family and friends have strong links / are members of proscribed organisations. |
| Child doesn't express support for extreme views or is too young to express such views themselves. | Child makes reference to own and family extreme views. | A child is known to live with an adult or older child who has extreme views. Child may inadvertently view extremist imagery. | A child is sent extreme imagery / taken to demonstrations or marches where violent, extremist and/or age inappropriate imagery or language is used. The child/carers/ close family members / friends are members of prescribed organisations, promoting the actions of violent extremists and/or saying that they will carry out violence in support of extremist views including child circulating violent extremist images |
| Child engages in age appropriate use of internet, including social media | Child is at risk of becoming involved in negative internet use that will expose them to extremist ideology, expressing casual support for extremist views. | Child is known to have viewed extremist websites and has said s/he shares some of those views but is open about this and can discuss the pros and cons or different viewpoints. | Child is known to have viewed extremist websites and is actively concealing internet and social media activities. They either refuse to discuss their views or make clear their support for extremist views. Significant concerns that the child is being groomed for involvement in extremist activities. |
| Child engages in age appropriate activities and displays age appropriate behaviours and self-control. | Child is expressing strongly held and intolerant views towards people who do not share their religious or political views. | Child is refusing to co-operate with activities at school that challenge their religious or political views, they are aggressive and intimidating to others who do | Child expresses strongly held beliefs that people should be killed because they have a different view. Child is initiating verbal and sometimes physical conflict |

| | | | |
|---|---|---|---|
| | | not share their religious or political views. | with people who do not share their religious or political views. |
| Child engages in age appropriate activities and displays age appropriate behaviours and self-control. | The child is expressing verbal support for extreme views some of which may be in contradiction to British law. | Concerns child has connections to individuals or groups known to have extreme views and they are being educated to hold intolerant, extremist views | Child has strong links and involved in activities and being educated by those with individuals or groups who are known to have extreme views / links to violent extremism. |

| DRUG / SUBSTANCE MISUSE | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| The child has no history of substance misuse or dependency. | The child is known to be using drugs and alcohol frequently with occasional impact on their social wellbeing. | The child's substance misuse dependency is affecting their mental and physical health and social wellbeing - Child presents at hospital due to substance / alcohol misuse. Carer indifferent to underage smoking / alcohol / drugs etc | The child's substance misuse dependency is putting the child at such risk that intensive specialist resources are required |
| Carers/other family members do not use drugs or alcohol or the use does not impact on parenting. | Drug and/or alcohol use is impacting on parenting but adequate provision is made to ensure the child's safety, concerns this may increase if continues. | Drug/alcohol use has escalated to the point where the child is worrying about their carer/family member. | Carer/other family members drug and/or alcohol use is at a problematic level and are unable to provide care to child. |
| No signs or suspicion of drug usage | Child or household member found in possession of Class C drugs | Previous concerns of drug involvement / drug supply and child or household member found in possession of Class A or Class B drugs / drug paraphernalia found in home. | Family home is used for drug taking / dealing / illegal activities. |
| No signs or suspicion of drug usage | Concerns of drug usage during pregnancy | Evidence of substance/drug misuse during pregnancy – pre 21 weeks gestation. | Evidence of substance/drug misuse during pregnancy – post 21 weeks gestation |

| DISABILITY | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Carers / other family members have disabilities which do not affect the care of their child. | Carers / other family members have disabilities which occasionally impedes their ability to provide consistent patterns of care but without putting the child at risk, additional support required. | Carers / other family members have disabilities which are affecting the care of the child. | Carers / other family members have disabilities which are severely affecting the care of the child and placing them at risk of significant harm |
| Child has no apparent disabilities. | Additional help required to meet health demands of the child's disabilities. | Parents unable to fully meet the child's needs due disability needs, requiring significant support under CIN Plan. | Carers Child's disability needs not being met - neglectful |

| YOUNG CARER | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Child does not have any caring responsibilities | Child occasionally has caring responsibilities for members of their family and this sometimes impacts on their opportunities | Child is regularly caring for another family member resulting in their development and opportunities being adversely impacted by their caring responsibilities | Child's outcomes are being adversely impacted by their unsupported caring responsibilities |

| DOMESTIC ABUSE | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Expectant mother or parent is not in an abusive relationship. | Expectant mother or parent is a victim of occasional or low-level non-physical abuse. | Expectant mother or parent has previously been a victim of domestic abuse and is a victim of occasional or low-level non-physical abuse | Expectant mother or parent is a victim of domestic abuse which has taken place on a number of occasions |
| No history or incidents of violence, emotional abuse / economic control or controlling or coercive behaviour in the family. | There are isolated incidents of physical / emotional abuse / economic control or controlling or coercive behaviour in the family, however mitigating protective factors within the family are in place. Even if children reported not to be present when incidents have occurred. | Children suffering emotional harm when witnessing physical / emotional abuse / economic control / coercive and controlling behaviour within the family. Perpetrator/s show limited or no commitment to changing their behaviour and little or no understanding of the impact their behaviour has on the child. | Evidence suggesting child is directly subjected to verbal abuse, derogatory titles, and threatening and/or coercive adult behaviours. Child suffering emotional harm and possibly physical harm when witnessing / involved with physical / emotional abuse / economic control / coercive and controlling behaviour within the family especially if they are trying to protect the adult victim. Frequency of incidents increasing in severity / duration |
| . | Information has become known that a person living in the house may be a previous perpetrator of domestic abuse, although no sign of current or recent abuse is apparent. | Confirmation previous domestic abuse perpetrator residing at property. Carer minimises presence of domestic abuse in the household contrary to evidence of its existence. | Serious threat to parent's life or to child by violent partner. Child injured in domestic violence incident. Child traumatised or neglected due to a serious incident of DV or child is unborn. |

| SOCIAL DEVELOPMENT | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| Child has good quality early attachments, confident in social situations with strong friendships and positive social interaction with a range of peers, demonstrating positive behaviour and respect for others. | Child has few friendships and limited social interaction with their peers. Child has communication difficulties and poor interaction with others. Child exhibits aggressive, bullying or destructive behaviours which impacts on their peers, family and/or local community. Support is in place to manage this behaviour. Child is a victim of discrimination or bullying. | Child is isolated and refuses to participate in social activities, interacting negatively with others including aggressive, bullying or destructive behaviours, early support has been refused, or been inadequate to manage this behaviour. Child has experienced persistent or severe bullying which has impacted on his/her daily outcomes. Child has significant communication difficulties. | Child is completely isolated, refusing to participate in any activities, positive interaction with others is severely limited due to displays of aggressive, bullying or destructive behaviours impacting on their wellbeing or safety. Child has experienced such persistent or severe bullying that his/her wellbeing is at risk. Child has little or no communication skills |
| There is a positive family network and good friendships outside the family unit. | There is a significant lack of support from the extended family network which is impacting on the parent's capacity. | There is a weak or negative family network. There is destructive or unhelpful involvement from the extended family. Child has multiple carers; may have no significant or positive relationship with any of them/child has no other positive relationships. | The family network has broken down or is highly volatile and is causing serious adverse impact to the child |
| Child engages in age appropriate use of internet, gaming and social media. | Child is at risk of becoming involved in negative internet use, lacks control and is unsupervised in gaming and social media applications | Child is engaged in or victim of negative and harmful behaviours associated with internet and social media use or is obsessively involved in gaming which interferes with social functioning. Evidence of sexual material being | Child is showing signs of being secretive, deceptive and is actively concealing internet and social media activities. Regularly coerced to send / receive indecent images. Coerced to meet in person for sexual activity. Devices need to be removed |

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|---|---|---|---|
| | | shared without consent. Multiple SIMs or phones. | and access restricted at all times |
| The family feels integrated into the community. | The family is chronically socially excluded and/ or there is an absence of supportive community networks. | The family is socially excluded and isolated to the extent that it has an adverse impact on the child | The family is excluded and the child is seriously affected but the family actively resists all attempts to achieve inclusion and isolates the child from sources of support |
| The neighbourhood is a safe and positive environment encouraging good citizenship and knowledgeable about the effects of crime and anti-social behaviour | Child is affected and possibly becoming involved in low level anti-social behaviour in the locality due to others engaging in threatening and intimidating behaviour | The neighbourhood or locality is having a negative impact on the child resulting in the child coming to notice of the police on a regular basis both as a suspect and a victim, concerns by others re exploitation. | The neighbourhood or locality is having a profoundly negative impact on the child resulting in the child coming to notice of the police on a regular basis both as a suspect and a victim, concerns by others re high risk of exploitation, being groomed and any other criminal activity. |
| Child and family is legally entitled to live in the country indefinitely and has full rights to employment and public funds. | Child and family's legal entitlement to stay in the country is temporary and/or restricts access to public funds and/or the right to work placing the child and family under stress. | Child and family's legal status puts them at risk of involuntary removal from the country / having limited financial resources/no recourse to public funds increases the vulnerability of the children to criminal activity. | Evidence a child has been exposed or involved in criminal activity to generate income for the family / family members are being detained and at risk of deportation or the child is an unaccompanied asylum-seeker. |
| Young person is positively engaging with services. Has awareness of the risks and grooming processes. Motivated and positive outlook. | Perceived inability or reluctance to access more mainstream support. Reduced access due to their ethnicity / cultural background / being in care / Identifying as LGBTQ / Educational Needs (SEN). | Isolated and refuses to participate in activities. Experiencing bullying or social isolation that may be exacerbated by personal, cultural, sexual identity or education needs. Targeted by groups or individuals due to their vulnerability or perceived reputation. | Negative sense of self and abilities that risk of causing harm. Completely isolated, refusing activities. High levels of social isolation that may be exacerbated by personal, cultural, sexual identity or education needs. |

| **EXTRA-FAMILIAL HARM** | | | |
|---|---|---|---|
| **Level 1** | **Level 2** | **Level 3** | **Level 4** |
| **PLACES/SPACES** | | | |
| Good services in area and young person is aware / engaging positively. Guardians in area ensure physical and psychological wellbeing of young people. | Spending time in areas known for antisocial behaviour or where more vulnerable. Child/ young person identifies and informs professionals of unsafe locations and reason for this. | The neighbourhood or locality is having a negative impact on the child. Frequently spending time in locations, including online, where they can be anonymous or at risk of experience harm / violence / exploitation. | Found in areas/properties known for exploitation / violence. Taken to hotel / B&B / property with intention of being harmed or harming others. Area having profoundly negative effect on the child |
| **PEER GROUP/EXTERNAL RELATIONSHIPS** | | | |
| Peer group engage in positive activities / clubs / communities. The group understands risk and harm. Age appropriate and safe. Peers that have 'turned around' in their journey. | Some indications that unknown adults and/or other exploited children have contact with the child/young person. Some indications of negatively influential peers. | Unknown adults and/or other exploited children/young people associating with the child/young person. Escalation in behaviour of peer group. Accompanied by an adult who is not a legal guardian. Arrested with individuals who at risk of exploitation / violence. | Staying with someone believed to be exploiting them. Person with significant relationship is coercing child / young person to meet and child is sexually or physically abused. Found with adults / high risk individuals out of borough. Is being exploited to 'recruit' others |
| **PROFESSIONAL ENGAGEMENT** | | | |
| Trusted adult in professional network. Impactful | Limited referral history with services. Lack of confidence in worker / service to | Services previously involved and closed; new referral received for similar | History of multiple services / referrals with little change or escalation in risk. Services |

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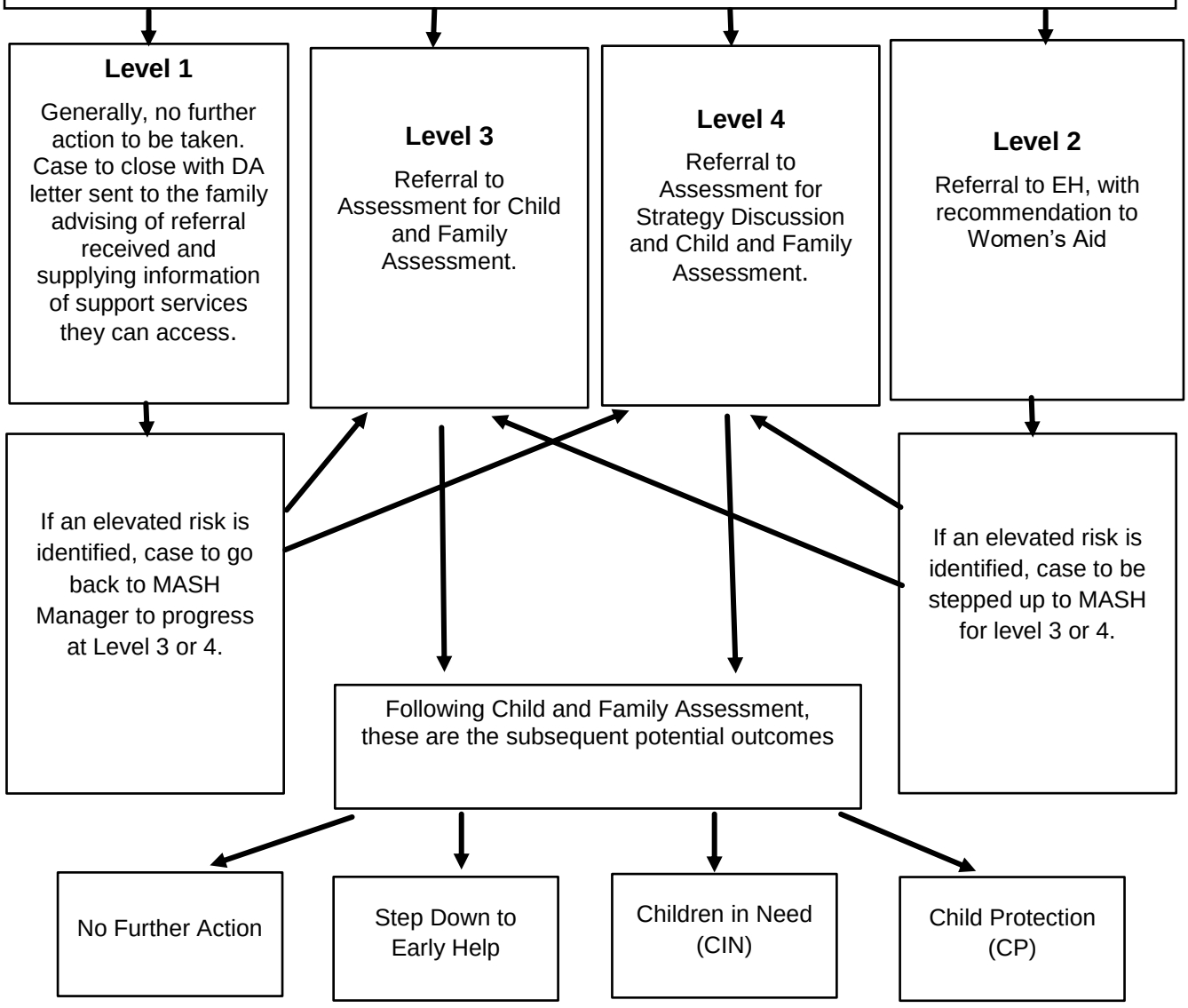
| engagement. Curious and flexible. | manage risk or work with adolescents. Multiple workers confused or disagreeing on risk. | concerns. Despite attempts, professionals have been unable to engage the young person to date. Several services involved but little change. | report unable to keep child / young person safe. |
| **MISSING** | | | |
| Child comes homes on time and does not run away from home. Their whereabouts are always known to their carers and they answer their phone. | Child has run away from home on one or two occasions or not returned at the normal time. Concerns about what happened to them whilst they were away, whereabouts unknown. | Child persistently runs away and/or goes missing, serious concerns about their activity whilst away. Parent does not report them missing. Unable to give explanations for whereabouts. | Child persistently runs away and/or goes missing and does not recognise that he/she is putting him/herself at risk of exploitation, criminal behaviour etc. Pattern of sofa surfing, whereabouts unknown |

## DOMESTIC ABUSE PATHWAY

When a Domestic Abuse (DA) referral/merlin is received. The MASH Manager will use the threshold document to inform their decision and follow the pathway as below.

Check Protocol to see if family are known. Information shared internally and with partner agencies. Refer to Barnardos risk assessment matrix

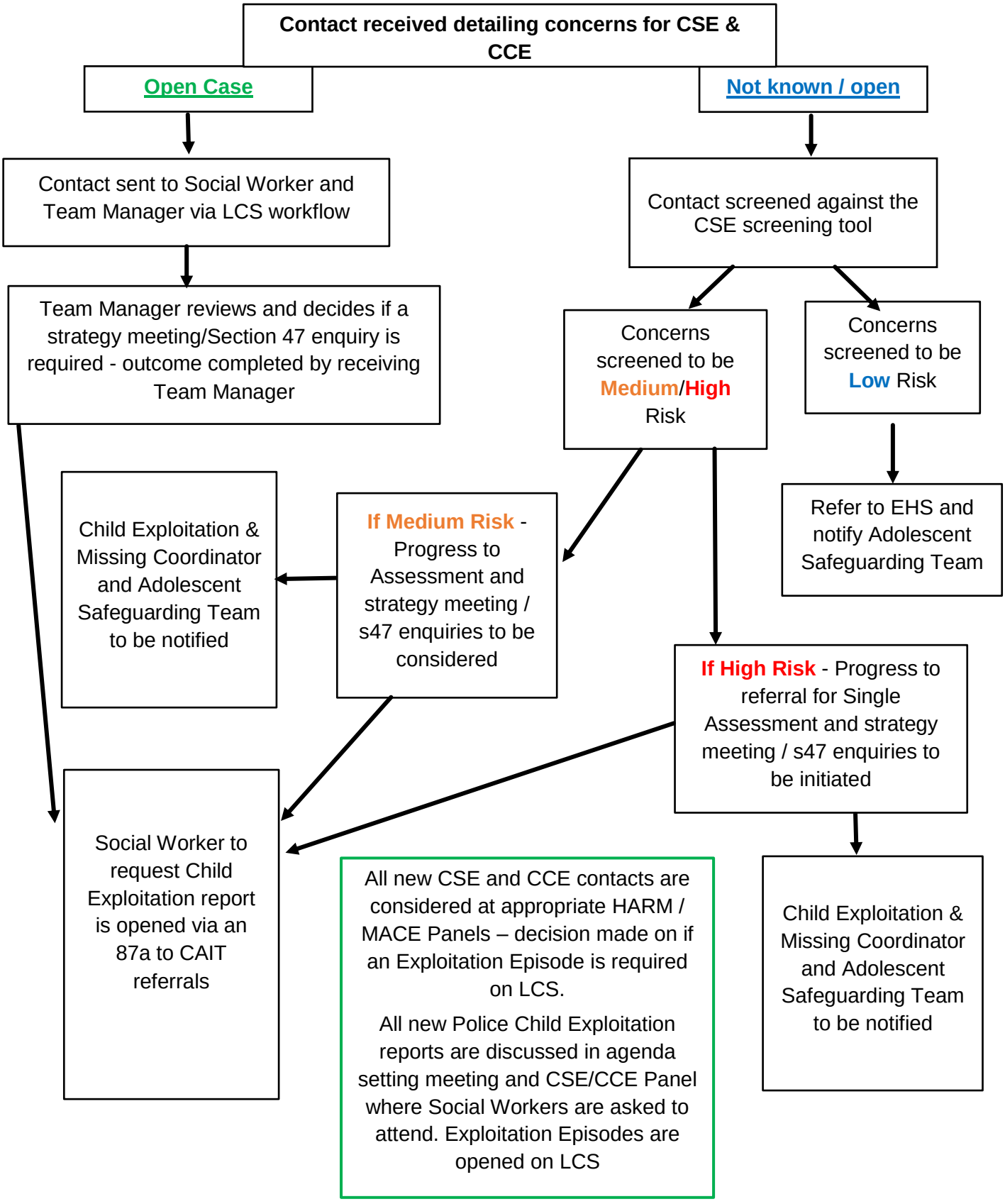
At any of these threshold stages the manager may decide further information is required. A SW will be asked to complete further MASH checks under the Havering MASH Criteria guidelines to gather further information and decide overall threshold. Safe Lives Dash risk checklist to be completed.




**Consideration for aMulti-AgencyRisk Assessment Conference (MARAC)**

A MARAC is used to reduce the risk of serious harm for a domestic abuse victim and to increase the safety, health and well-being of other victims, both adults and children. A referral can be made to MARAC panel following completion of the Safe Lives Dash Risk checklist. Should a victim score 14 or more a referral is required, *however referrals can also be made based on professional judgement even if score is lower.*

## CHILD SEXUAL EXPLOITATION (CSE) & CHILD CRIMINAL EXPLOITATION (CCE) PROCESS CHART



## HAVERING CHILD SEXUAL EXPLOITATION SCREENING THRESHOLD TABLE

This threshold tool has been developed for the purpose of screening child sexual exploitation cases and is based upon the London Child Exploitation Operating Protocol (April 2021) and the London Child Protection Procedures Safeguarding Children from Sexual Exploitation (6th Edition, 2020).

Please note the table operates an escalation process therefore risk factors in low risk, will also be evident in medium risk and low and medium risk in high risk. This framework needs to be used flexibly to take account of each child's individual circumstances and consider these holistically.

This tool is to enable MASH staff to assess a child's level of risk of CSE in a quick and consistent manner. It can be applied to all children, male and female, under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex and even if the sexual activity appears consensual. It is important that such abuse is not overlooked due to assumed capacity to consent.

Sexual exploitation is a form of Modern Day Slavery and can have links to other types of crimes. These include but are not restricted to Child trafficking; Domestic abuse; Sexual violence in intimate relationships; Grooming (including online grooming); indecent images of children and their distribution; Drugs-related offences; Gang-related activity; Immigration-related offences; Domestic servitude.

| CATEGORY OF RISK | DESCRIPTIONS OF RISK | OUTCOMES |
|---|---|---|
| **Low Risk**<br><br>A vulnerable child who is at risk of being targeted and groomed for sexual exploitation. | • 1-2 episodes of missing from home/care or regularly coming home/to placement late<br>• Absent from school<br>• Youth produced sexual imagery.<br>• Meeting unknown people through social media/internet<br>• Low self-esteem / self-confidence / poor self-image<br>• Difficulty maintaining friendships/reduced contact with family or friends<br>• Learning difficulties.<br>• Mental health concerns.<br>• Confusion relating to sexual and/or gender orientation. | • Threshold met for a child with additional needs.<br>• Single agency response.<br>• Consider Early Help Intervention<br>• Alert child to the Adolescent Safeguarding Service.<br>• If deemed necessary. Details of the contact will be raised in HARM Panel. |

| | | |
|---|---|---|
| | • Boyfriend/girlfriend known to services<br>• Associating with other sexually exploited / missing children<br>• | |
| **Medium Risk**<br><br>.<br><br>**Category 2: Medium Risk**<br>A child who is targeted for opportunistic abuse through the exchange of sex for drugs, accommodation, and goods. The likelihood of cohesion and control is significant. | The above plus indicators including:<br><br>• Regularly missing/frequently staying out overnight without permission.<br>• Increasingly secretive<br>• Access to premises unknown to parent/carer<br>• Receipt of Unexplained Gifts or Money.<br>• Alcohol and/or Drug Misuse (new or increasing).<br>• Changes in behaviour i.e. violent/emotional outbursts and/or threatening behaviour<br>• Involvement in crime or increase in offending.<br>• Non-school attender/risk of exclusion due to behaviours exhibited<br>• Affiliated with gang members or people known to SYV Panel/known to be in a relationship with a suspected gang member.<br>• Extensive use of mobile phone / secretive about use / have more than 1 phone<br>• Evidence of sexually transmitted infections, pregnancy and termination. Inappropriate sexualised behaviour for their age.<br>• Unexplained injuries or changes to physical appearance.<br>• Thoughts of or attempts of self-harm and suicide.<br>• Disclosures of physical/sexual assault which are then retracted.<br>• Familial sexual abuse, physical abuse, emotional abuse, neglect, DA, parental mental ill health or | • Threshold met for Child in Need in Havering.<br>• Multi-Agency response required.<br>• Single Assessment to be completed and HARVA risk assessment to inform decision making and plans for the child.<br>• Alert to be sent to iass@havering.gov.uk and will be determined if needed to be discussed at HARM Panel.<br>• Alert child to the Specialist Safeguarding Service.<br>• Consideration to be given to requesting a Police Child Exploitation report been generated and strategy meeting held. |

| | | |
|---|---|---|
| | substance misuse, parental criminality, homelessness, living in care.<br>• Any behaviours indicating CSE of a child under the age of 13.<br>• Linked to indecent images.<br>• 'relationship' with controlling individuals | |
| **High Risk**<br><br>Evidence or strong suspicion of a child being targeted for CSE including opportunistic or habitual abuse and where the likelihood of coercion and control is significant. This will be through the exchange of sex for drugs, perceived affection, sense of belonging, accommodation, money and goods etc. This will also include a child being sexually exploited through the use of technology and without the child receiving any reward i.e. the exchange of indecent images on line.<br><br>The child's sexual exploitation is / can be self-denied and coercion / control is implicit. This can be carried out by multiple perpetrators. | The above plus indicators including:<br><br>• Persistently going missing<br>• Distrust of authority figures.<br>• Problematic substance misuse/ addiction.<br>• Chronic/increased self-harm and deterioration in mental and emotional well being<br>• Gang involvement/affiliation.<br>• Linked to areas/properties known for or suspected for county lines/'crack houses'<br>• Children under 13 engaging in sexual activity with another over 15 years old (*n/b this is statutory rape*).<br>• Older boyfriend (at least 5 years older).<br>• Has limited or no appropriate/healthy relationships or connections<br>• Clipping. (when children say they will perform sexual acts on someone for money and then flee)<br>• Child is forced or receives a reward to recruit others to being sexually exploited.<br>• Child is coerced or forced to perform sexual acts on others or have others perform sexual acts on them.<br>• Rape / Sexual Assault (including the making of disclosures and then retracting).<br>• Seen being picked up/dropped off by unknown adults | • Threshold met for Child Protection enquiries<br>• Multi-Agency response required.<br>• Child and Family Assessment to be completed and CSE risk assessment.<br>• Request to be made for a Police Child Exploitation report to be generated<br>• Strategy meeting and Section 47 required.<br>• Alert to be sent to the Child Exploitation & Missing Coordinator where they will be raised in the next CSE/CCE Panel.<br>• Alert child to the Adolescent Safeguarding Team |

## CRIMINAL EXPLOITATION MASH THRESHOLD MATRIX

This threshold tool has been developed for the purpose of screening Child Criminal Exploitation cases and is based upon the London Child Exploitation Operating Protocol (April 2021). And the London Child Protection Procedures Safeguarding Children from Sexual Exploitation (6th Edition 2020)

Child Criminal Exploitation is a form of Modern Day Slavery and can have links to other types of crimes. These include but are not restricted to Child trafficking; Domestic abuse; Grooming (including online grooming); indecent images of children and their distribution; Drugs-related offences; Gang-related activity; Immigration-related offences; Domestic servitude.

This tool is to enable MASH staff to assess a child's level of risk of CCE in a quick and consistent manner and is to be used to determine the referral threshold for Child Criminal Exploitation. It can be applied to all children, male and female, under the age of 18 years. It is important that such abuse is not overlooked due to assumed capacity to consent to any behaviours. Whilst considering the below factors please also consider the pull factors for children such as home circumstances. This includes children from neglectful homes and ones where family conflict and domestic abuse have shaped their world view. It also includes children where there is an absence of a primary or protective attachment figure.

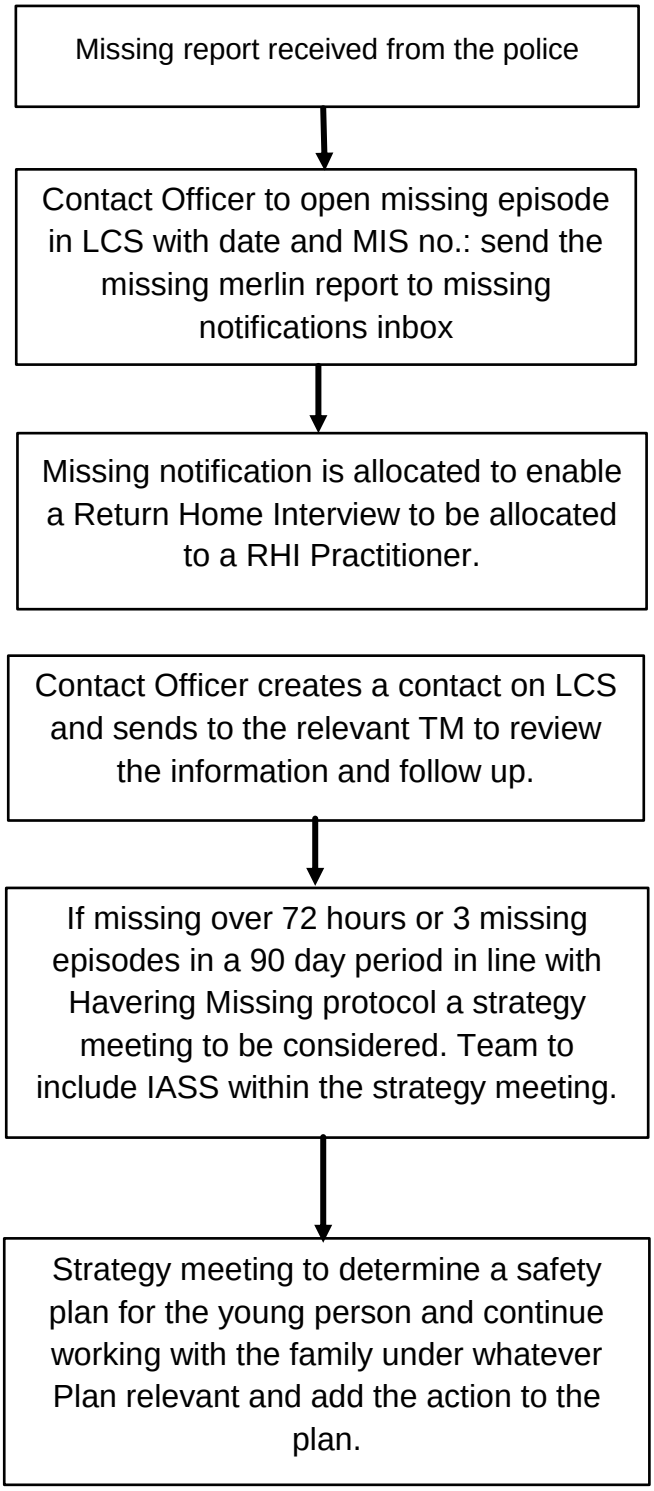
Please note the table operates an escalation process therefore risk factors in low risk, will also be evident in medium risk and low and medium risk in high risk. This framework needs to be used flexibly to take account of each child's individual circumstances and consider these holistically.

| Threshold | Evidence of CCE | Havering Response |
|---|---|---|
| Level 1-2<br>Emerging risk | Carrying a knife in school / on street<br>Victim of bullying / crime<br>Possession of Class B drugs<br>Experimenting with cannabis and or alcohol<br>Starting to come home late or episodes of missing from home<br>Recent change in peer group / late night social media usage<br>Attendance or behavioural concerns at school<br>Low self-esteem / self-harm<br>Difficulty managing peer relationships | This is a child who is vulnerable and may have additional needs.<br><br>For all Low risk children , a notification must be sent to the Adolescent Safeguarding team for tracking purposes |

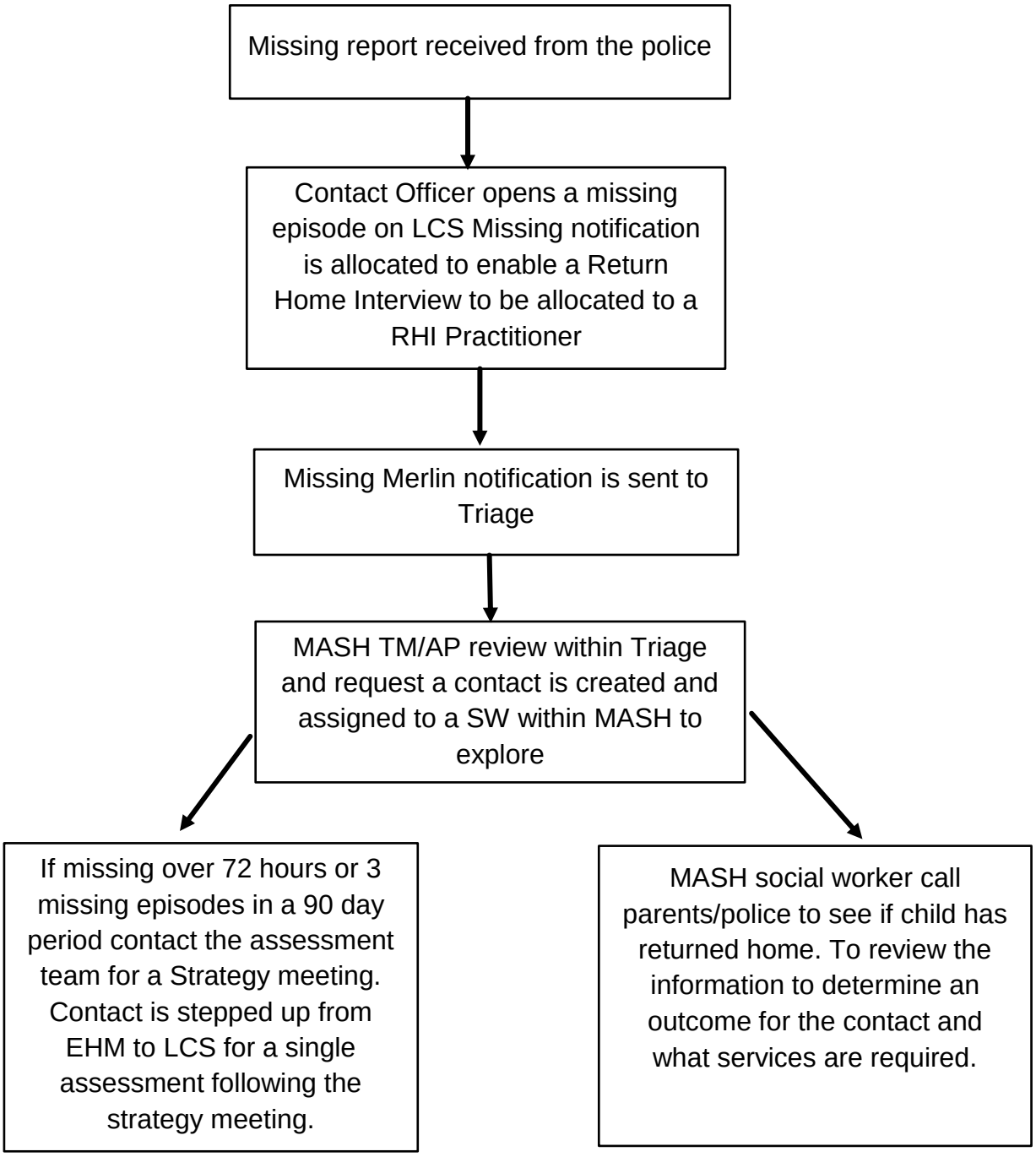
| | | |
|---|---|---|
| | Coming to police notice for theft under £500 | |
| Level 3<br>Moderate risk | Child in receipt of gifts, trainers, money, drugs.<br>Frequent episodes and periods of going missing<br>Regular or increased use of drugs / substances<br>Irregular school attendance, taunting, loss of interest in education<br>Violent or emotional outbursts<br>Victim of violence<br>Arrested by police for possession of drugs / carrying an offensive weapon<br>Repeat incidents of theft of high value items or first offence totalling over £500<br>Evidence of bank transfers, money laundering via young person's bank account<br>Associating / 'hanging out' with over 25-year olds | The child is experiencing extra family harm which is placing their safety and wellbeing at risk.<br>Adolescent Safeguarding team must be informed. The team can provide a case overview/consultation.<br>A member of contextual safeguarding team will be available to attend multi-agency meeting<br>Single Assessment |
| Level 4<br>Significant risk | Possession and supply of Class A drugs<br>Coercion to supply, transport or deal drugs<br>County Lines involvement<br>Organised theft to the value of over £1000<br>Blood in child's underwear indicating drugs carried in vagina / anus or sexual assault<br>Trafficking<br>Violence / intimidation<br>Persistent episodes and periods of going missing, missing longer than 24 hours and overnight<br>Evidence of drug dependency<br>Not in education / Breakdown of education placements<br>Serious mental ill, health / suicidal ideation<br>Frequent attendance at A and E / removal of ingested drugs | There is concern extra familiar harm is placing the child and others at risk immediate harm<br>*Single Assessment*<br>*Strategy Discussion.*<br>*Adolescent Safeguarding team must be informed of all high risk cases. The team will provide case overview/consultation and a member of adolescent safeguarding team can contribute to the assessment.*<br>*A Member of contextual safeguarding team will be available to attend any multi-agency meetings* |

| | | |
|---|---|---|
| | Police detention / secure accommodation request /Arrested for possession of large quantities of Class A drugs<br>On police gangs matrix / gang nominal<br>Indicators parents are also being exploited or the family home has been cuckooed<br>Residing in the same household as an immediate family member who is arrested for a serious offence such as murder, trafficking, organised crime, weapons and large quantities of class A drugs. Those with media interest require a NTK | |

## MISSING PERSON PROCESS FOR OPEN CASES



## MISSING PERSONS PROCESS FOR UNKNOWN CASES



## PROTOCOL FOR PRE BIRTH CASES

1. **Cases transferring directly to ISS from MASH – pre-birth –**

There are a number of pre-birth assessment cases that due to the poor prognosis would best be dealt with by ISS in order to minimise multiple workers and promote streamlined planning.

1. These are cases where there is more than a 75% chance of the case progressing to either **Pre or Legal proceedings.**
2. A **Havering** Care Leaver where there are concerns re parenting which is likely to require ISS intervention at CP level ( **care leavers from other boroughs are not included in this cohort unless they meet 75% prognosis**)

**Cases that are likely to meet this threshold are:**

1. History of previous children being removed by LB Havering
2. Recent history ( within the last 18 months) of previous children being removed by other LA's

**Process for transferring**

Once MASH have identified a case that meets the above there is to be a **face to face discussion** between MASH manager/ Service Manager and Service Manager from ISS either on the day or at the weekly transfer meeting.

**Cases are not to be transferred to the ISS inbox without there being discussion and agreement given, through management conversation or through the transfer meeting process**

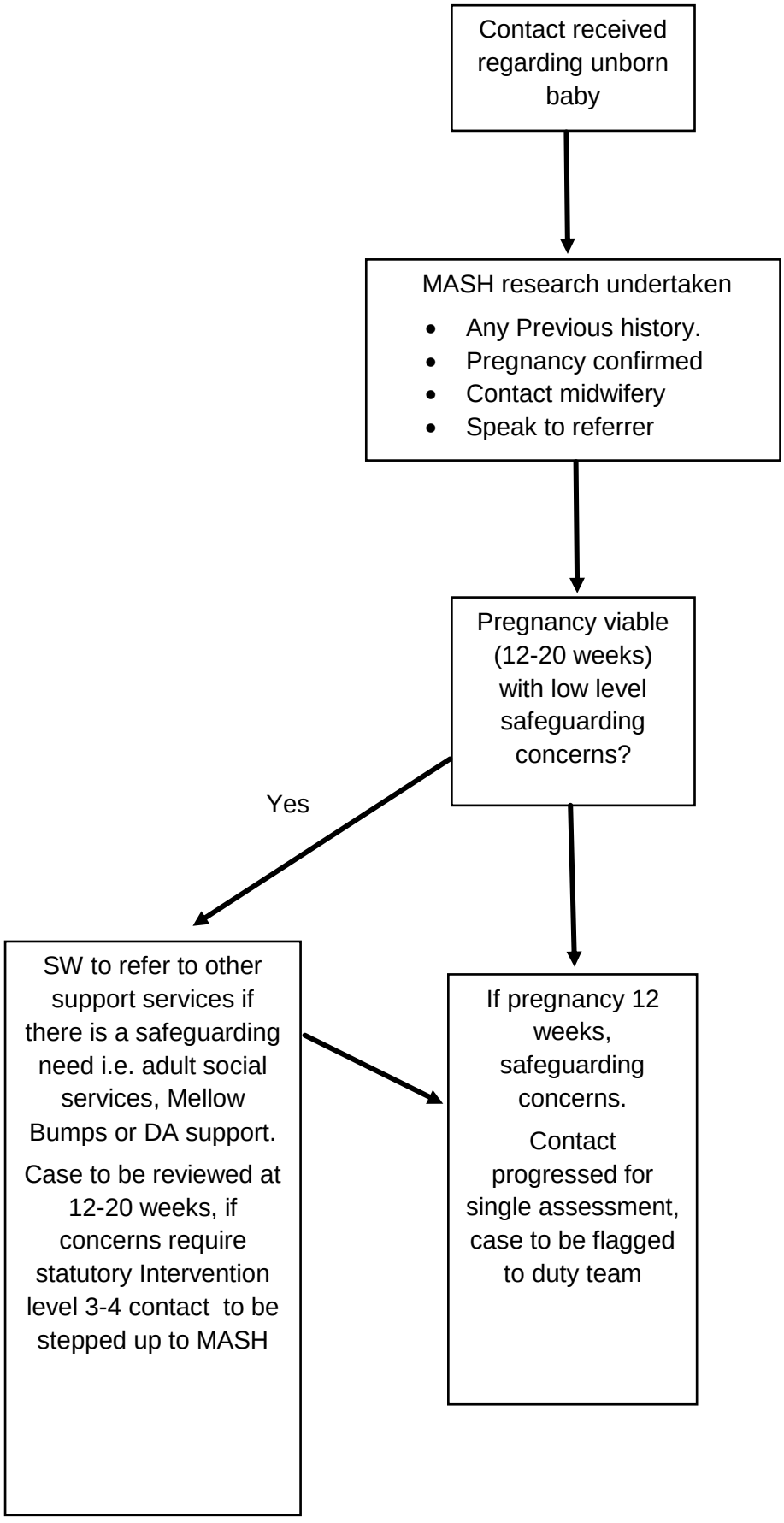
1. Should the Estimated Due Date (EDD) be within 12 weeks then there will be a discussion as to which service has capacity to undertake the assessment given the quick response that is needed.
2. There will need to be flexibility should ISS not be able to allocate immediately due to high demand
3. In the event there is a difference of opinion between the SM in MASH and ISS then this will be escalated to the Strategic Lead in ISS and MASH/ assessment

**All other pre-birth cases that do not meet the above criteria**

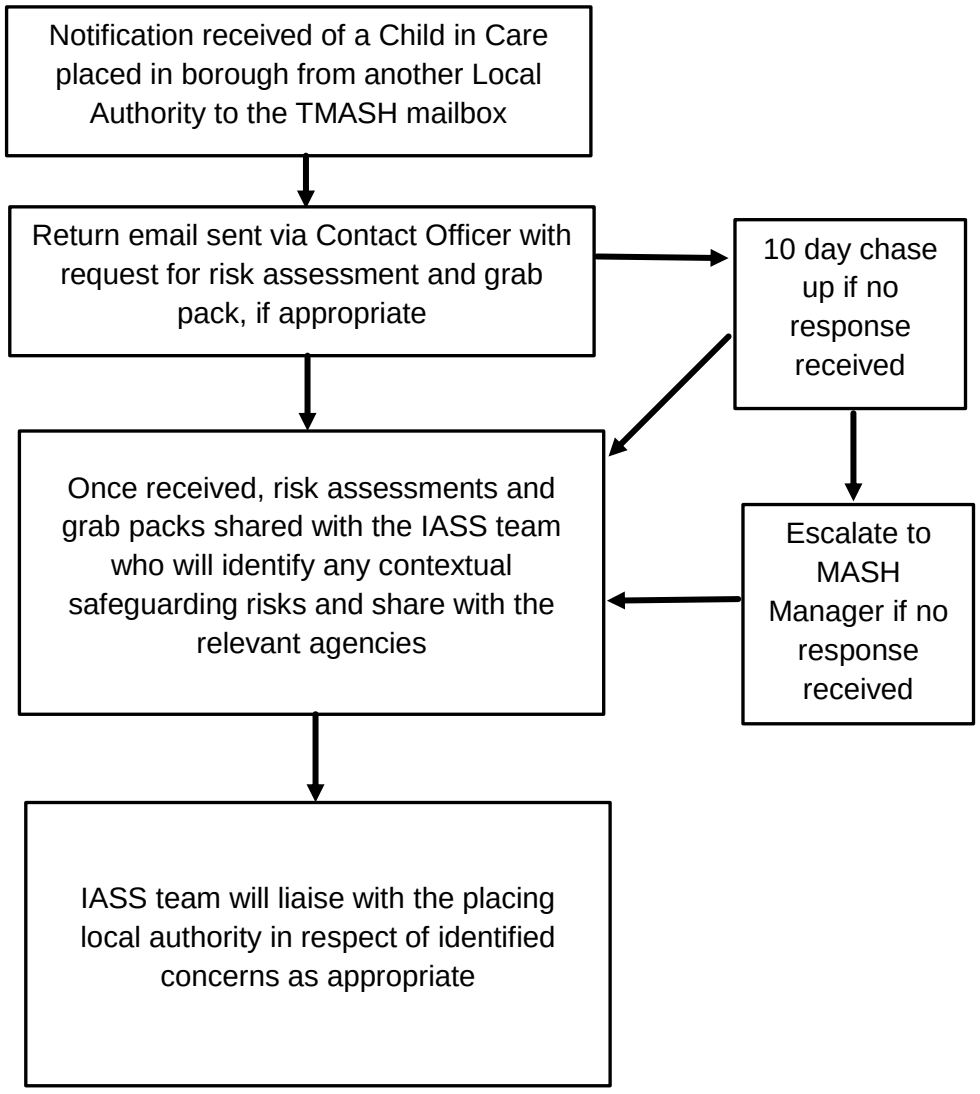
Other pre-birth cases will remain with the assessment service until transferred to ISS at initial pre-birth conference / multi-agency CIN meeting – 10 weeks prior to EDD.

**In principle cases will transfer approx. 10 weeks prior to EDD once a decision has been made regarding CIN/CP plan following full assessment.**

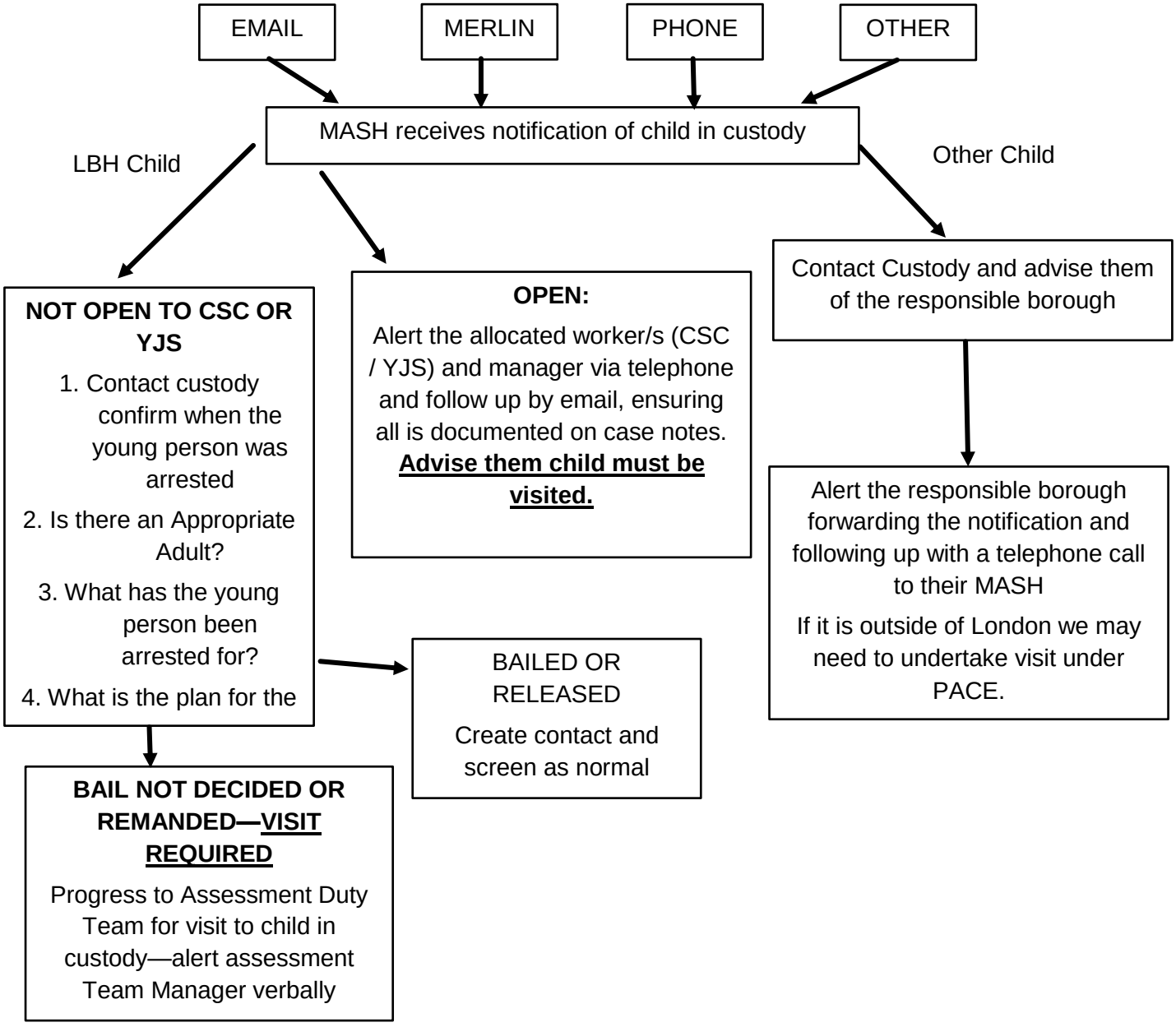
## PROCESS FLOW CHART FOR UNBORN SAFETY



## CHILD IN CARE TO ANOTHER LOCAL AUTHORITY PLACED IN HAVERING



## CHILD IN CUSTODY WORKFLOW




**REQUEST FOR SECURE ACCOMMODATION** Threshold is high; child must be 10+ and will need minister approval sought by the Director of Children Services. and one of the following: 1) Child would pose serious risk of harm to themselves or public before due to appear in court 2) The child has a history of absconding and is likely to abscond from any other accommodation and if they abscond would suffer significant harm. 3) If kept in any other accommodation they are likely to injure themselves or other persons.

Any disagreement between police and social care needs clear write up and escalation. Social care should escalate to Service Manager and then Strategic Head of Service if still not resolved. Police escalate to Sgt, then Inspector.

**REQUEST FOR NON- SECURE ACCOMMODATION** Social Care should confirm the reasons for the refusal of bail and understand the reasons why conditional bail is not possible. This all needs clear recording on file. Child in Care procedures to be initiated. It should also inform the decision as to what type of accommodation is suitable. It is social care who determines what "suitable" accommodation is. The family network should always be considered and explored first.

## WALK INS

**DOMESTIC ABUSE:**

The Duty Social Worker will complete the Safe Lives DASH MARAC risk assessment tool to assess the risk. If the issue has not been reported to the police, the Duty Social Worker will support the victim in accessing Police in order to report the incident. The Duty Social will explore living arrangements; and whether they are they safe to return home, or whether a refuge or presentation to the housing office is required under the DA rule.

**HOUSING:**

If a client presents as homeless, MASH SW to undertake an assessment. If it is imminent we need to progress to a single assessment.

**NRPF:**

If a client presents with NRPF, the Duty Social Worker will ascertain if the client / family are being supported by the UK Border Agency (UKBA) or the Home Office if the client has made an application at the Home Office for immigration status. If they have recourse to housing / financial support Duty SW will also consider whether an additional referral to early intervention is required. If not, and the family have no housing / finance and are in crisis, the XX SW will progress the referral through to the duty team for single assessment.

**BENEFITS:**

If a client presents with benefit problems, the Duty SW will need to get consent and details of the issues and any immediate financial difficulties. The XX will triage to understand whether consideration is to be given to refer straight to early intervention for advocacy support.

**NO FOOD / GAS / ELECTRIC:**

If the child / family present as having no money and are in crisis, the Duty SW will need to request evidence including bank statements to assess the current financial circumstances. The offer of food bank vouchers can be made. Section 17 payments can also be paid where required but will require an assessment or early help referral to assess the families ongoing financial situation.

**REPORTING A CONCERN FOR A CHILD:**

If someone comes in to report a concern about a child, Duty SW will ensure all the demographics including language and ethnicity are obtained from the referrer. Duty SW will then record these details on a contact on the Case recording system and send to the MASH Team manager for a threshold decision.

**PARENTING STRUGGLES:**

If a parent reports difficulty in parenting their child or states they can no longer cope, the Duty SW will also need to get as much information as possible to allow us to rate the threshold. One of the considerations will be if there has been any violence from parent to child or from child to parent? Based on information gathered the Duty SW will need to consider whether a referral to Early Help or a single assessment is required.

**PRIVATE LAW ISSUES:**

If a parent reports that the other parent has not allowed them contact with their child, we will need to explore whether this is a private law matter and signpost them to a family law solicitor. If the family are not know to the service.

## PRIVATE FOSTERING

All referrals for private fostering will be sent and received in the MASH. The Duty SW will follow the **Havering Private Fostering Checklist and**

**The Children (Private Arrangements for Fostering) Regulations 2005**

MASH – Triage (Amber) 24 hours to collect data, if PF (refer to PF checklist) case referred to Assessment Team.

Private Fostering identified**.** Immediate allocation required / Service Managers Assessment and Fostering

Three way meeting MASH, Assessment and Fostering. Information sharing session to assist the allocation of the case to assessment SW and SSW in Fostering

**Not a private fostering arrangement** and case follows alternative pathway

Not approved.

Alternative action taken

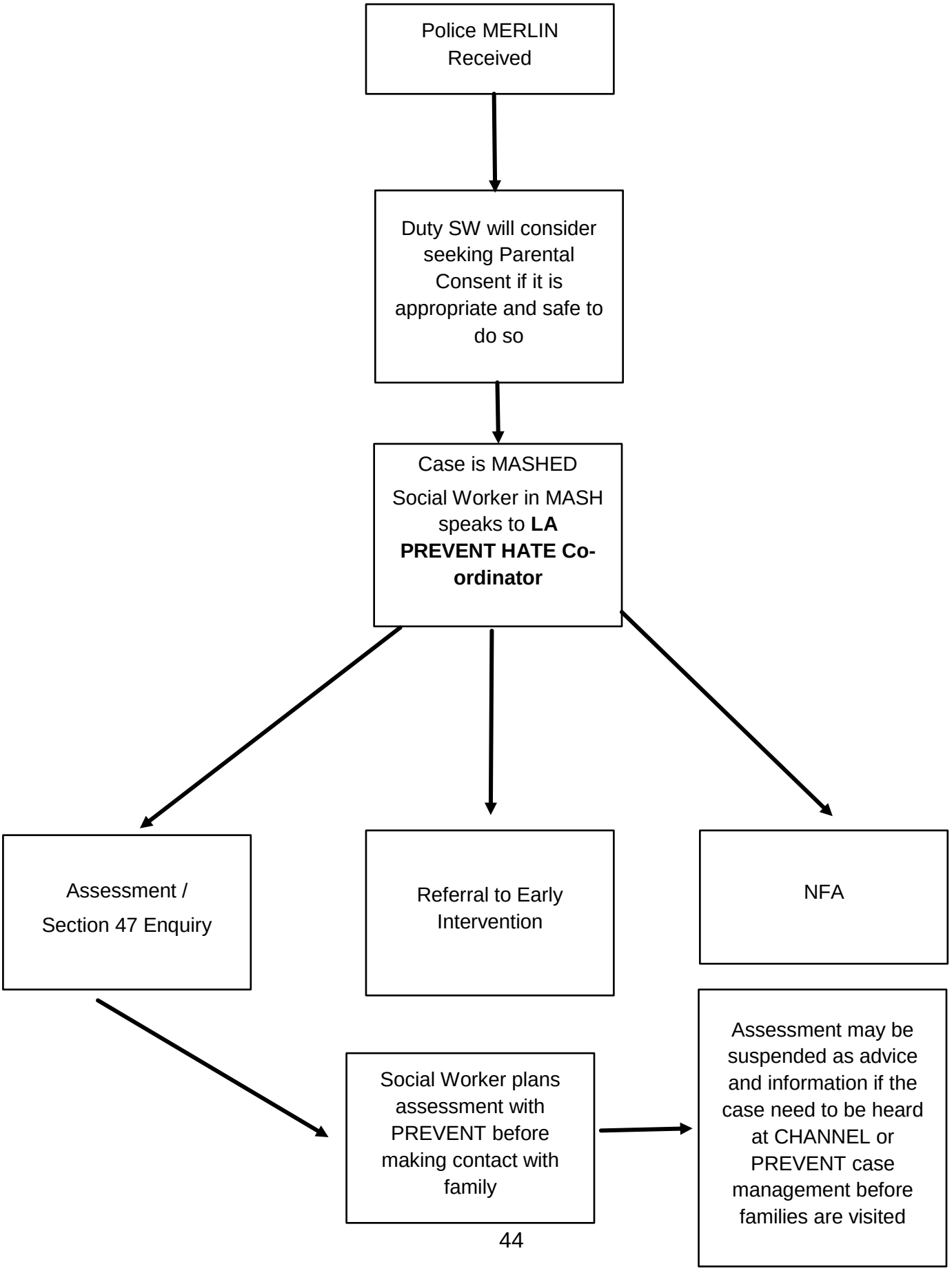
Child's case is both referred to the Assessment team for the child to have SW allocation and to Fostering for a SSW allocation. The Child MUST be seen within 7 working days of notification. Followed by 35 (max) days to complete the Private Fostering Assessment

A PF Carers Assessment is completed by the Fostering Service (lead assessor) in partnership with Childs SW social worker timescale 35 days.

Approval of carer by Fostering Service Manager by day 35. Fostering SSW & child SW undertake routine statutory visiting for first year and then review, until the child's 16th birthday, or 18 for a child with a disability.

**JOINT WORKING**

## CHANNEL WORKFLOW



## LB HAVERING CHILDREN'S SERVICES RISK ASSESSMENT TOOL FOR CHILDREN AT RISK OF RADICALISATION

Safeguarding children and young people from radicalisation is not dissimilar from safeguarding from other forms of harm/ exploitation. The table below highlights behaviours and vulnerabilities which can be categorised in terms of levels and indicators of risk. The table needs to be used flexibly to take account of each child's individual circumstances. The indicators are not exhaustive and a combination of factors in the low or medium categories may escalate risk. (Please also refer to the **tool for you to assess an individual's vulnerabilities to potential radicalisation.**)

| RISK CATEGORY | INDICATORS OF RISK | OUTCOMES |
|---|---|---|
| **Critical** | Encourages, justifies or glorifies terrorist violence to further particular beliefs.<br>Seeks to provoke others to undertake terrorist acts.<br>Encourages other serious criminal activity or seeks to provoke others to serious criminal acts.<br>Fosters hate which might lead to inter-community violence in the UK.<br>Possessing / accessing violent extremist literature. | Deemed Level 4 on the Havering Threshold Table.<br>Joint Section 47 enquiry police and social services visit to child or young person.<br>Police investigation required under 'Pursue' agenda.<br>Immediate discussion with Prevent co-ordinator. |
| **High** | Being in contact with extremist recruiters.<br>Accessing violent extremist websites, especially those with a social networking element.<br>Using extremist narratives and a global ideology to explain personal disadvantage.<br>Justifying the use of violence to solve societal issues.<br>Joining /seeking to join extremist organisations.<br>Lives with or is in direct contact with known terrorists. | Deemed Level 4 on the Havering Threshold Table.<br>Joint Section 47 enquiry police and social services visit to child or young person.<br>Immediate discussion with Prevent co-ordinator.<br>Case to be presented at the Channel Panel.<br>Police to consider if MAPPA processes apply. |

| RISK CATEGORY | INDICATORS OF RISK | OUTCOMES |
|---|---|---|
| **Medium** | Criminality: involvement with criminal groups, imprisonment and poor resettlement and reintegration.<br>Personal crisis: the young person is experiencing family tensions, isolation, and low self-esteem. They may have dissociated from their existing friendship group and become involved with a new and different group of friends. They may be searching for answers to questions about identity, faith and belonging. | Deemed Level 3 on the Havering Threshold Table.<br>Child and Family Assessment required.<br>Early discussion with **Prevent and Hate Co-ordinator. (Emily Knight)**<br>Case to be presented at the Channel Panel. |
| **Low** | **Identity crisis**: the young person is distanced from their cultural / religious heritage and experiences discomfort about their place in society.<br>**Personal circumstances**: migration, local community tensions. May feel aggrieved by a personal experience of their country of origin, racism or discrimination or Government policy.<br>**Unmet aspirations**: the young person may have perceptions of injustice, feelings of failure and rejection of civic life.<br>**Special Educational Need (SEN)**: the young person may experience difficulties with social interaction, empathy with others, understanding the consequences of their actions and awareness of the motivations of others.<br>Significant changes to appearance and/or behaviour.<br>MAC Counter Terrorism requests for information which highlight none of the above risk indicators. | Deemed Level 2 on the Havering Threshold Table.<br>Targeted intervention via School CAF or support from the Early Intervention Service.<br>Early discussion with Prevent co-ordinator.<br>Consideration for case to be heard at the Case Management Panel.<br>Explore mentoring for young person.<br>Provision of social care information to MAC. |

## THRESHOLDS FOR ELIGIBILITY FOR INTERVENTION BY SPECIALIST CHILDREN WITH DISABILITIES SERVICE

The following guidance is to be used in determining eligibility for intervention by Children and Young People with Disabilities (CYPWD)

Where a child's disability is permanent or long-term (lasting or expected to last for more than 1 year) and meets one of the criteria in the severe or profound category as outlined below they can be accepted for intervention by the Social Care Team within CAD.

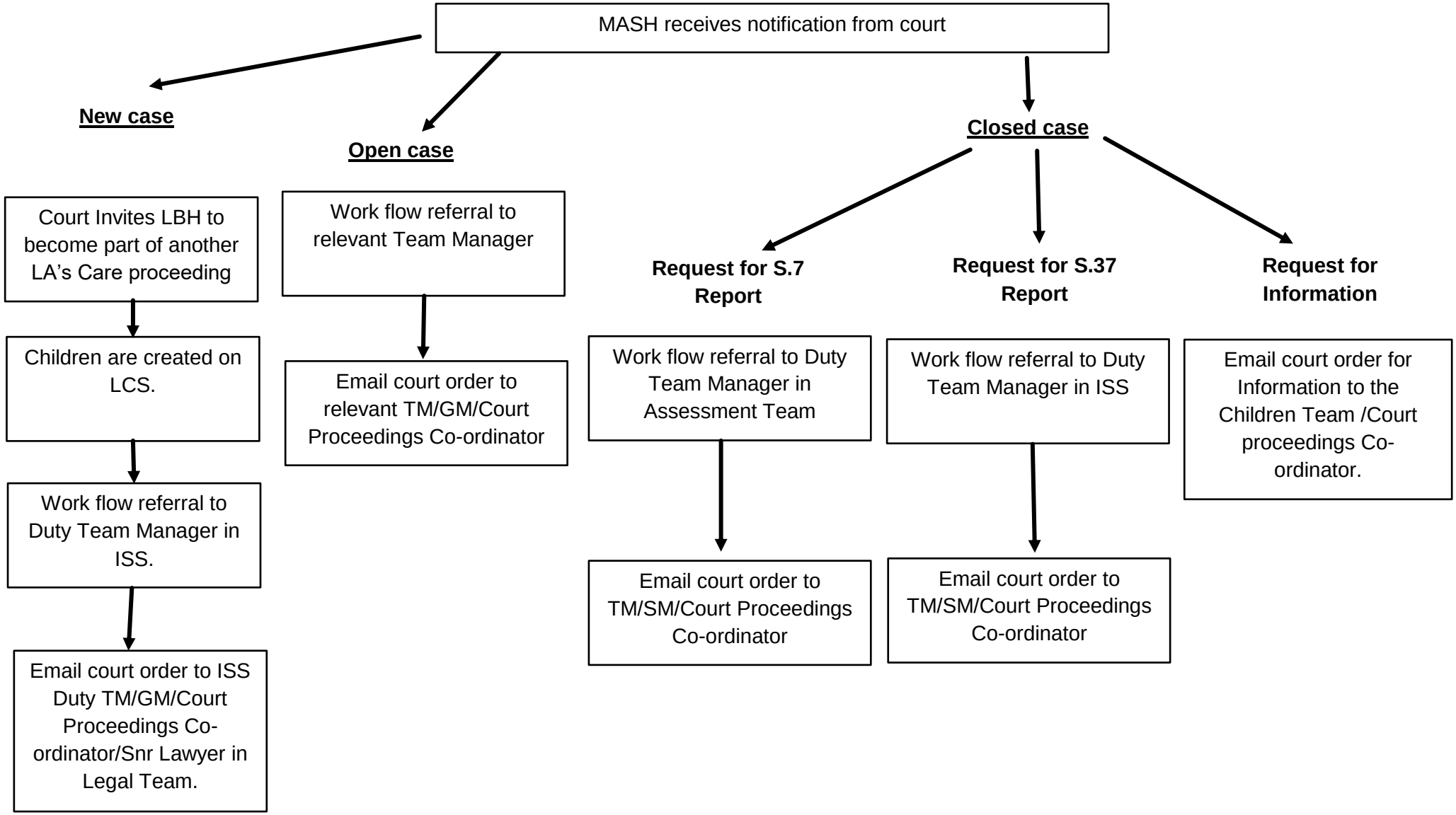
| Dimension | Mild | Moderate | Severe | Profound |
|---|---|---|---|---|
| Overall | Child under 5 functioning slightly behind the level expected for age. Child over 5, some limitation present but able to function independently. | Child under 5 functioning around 2/3yrs below what would be expected for their developmental age.<br><br>Child over 5 where aids or assistance may be required to perform normal activity. | Child under 5 functioning around ½ the level expected for their developmental age.<br><br>Child over 5 who is unable to perform tasks without aids or assistance. | Child under 5 requiring significantly greater care and attention because of the profound learning/ physical disability, complexity of health needs.<br>Significant failure to reach developmental milestones. Child over 5 completely dependent upon carer to perform tasks over and above what expected of that child s age. |
| Mobility | Able to walk and function independently but with some limitation of function. Poor co-ordination. | Walks but only with aids or assistance.<br>May have wheelchair for occasional and intermittent use. | Unable to walk. May be able to stand or transfer with support. Has limited ability to move around independently. | Unable to walk. Wheelchair user. Totally dependent upon care for mobility. |
| Motor Skills | Some difficulties with play, writing or drawing e.g. tremor, unsteadiness, awkward release, lack of control. | Able to play, write, type or draw but only with considerable difficulty or needing assistance. | Mostly unable to use hands effectively but able to use switch systems e.g. toys, computer, communication aid. | Unable to operate even simple aids or switch systems. |

| | | | | |
|---|---|---|---|---|
| **Dimension** | **Mild** | **Moderate** | **Severe** | **Profound** |
| Communication | Delayed language development only. | Delayed or disordered communication including language disorders causing significant difficulty in communicating outside the home. Speech supplemented by alternative method of communication, inability to use communication in a socially interactive manner. | None or very little communication used, but can communicate at least basic needs using any method such as PECs, Visuals, Makaton | Unable to communicate needs by any method. Unable to use communication aid. |
| Consciousness | Occasional daytime seizure activity up to one per month.<br>Managed with medication | Some seizure activity most weeks, day or night.<br>Managed with medication | Many seizure activity on most days or nights. Developmental and/or education needs are adversely affected. | Comatose, intractable seizures in frequent succession. |
| Health | Known health condition, which is under control and only occasionally interfering with everyday activities in a minor way. | Intermittent but regular limitations of normal activities, including self-care and personal hygiene. May interfere with development or education. | Frequent or daily interruption of normal activities, including self-care and personal hygiene. Significant interference with normal development or education. | Unable to take part in any social or educational activities. Unable to manage any self-care or personal hygiene functions. |
| Vision | Severe or profound problem with one eye. Less than half visual field loss. Able to function independently. | Able to read print with simple aids or assistance. Defect of at least half visual field. May be eligible for registration as partially sighted. | Unable to read large print without intensive educational assistance or sophisticated aids. Severe visual field defect with impaired visual acuity. | Mobility restricted without special provision. Requires above and beyond additional support to reach their expectations in education and |

| | | | | |
|---|---|---|---|---|
| | | | Unable to access activities without assistance<br>Eligible for registration as blind or partially sighted. | social needs. Registered or Eligible for registration as blind. |
| **Dimension** | **Mild** | **Moderate** | **Severe** | **Profound** |
| Hearing | Severe profound hearing loss in one ear. Hearing loss 20-40 dB. | Hearing loss 41 – 70 dB. | Hearing loss 71 – 95 dB | Hearing loss >95 dB. |
| Continence | Manages independently, without use of aids but with slight difficulty. Over 6 and regularly wets the bed. | 11+ with regular night time wetting.<br>8+ with occasional day time wetting.<br>6+ and soils occasionally.<br>Marked interference with social and emotional well-being. | Uses device to manage bladder and bowels.<br>8+ and wet every daytime.<br>6+ and soils regularly. | No control of either bowel or bladder. Child over 6 completely dependent upon carer to be clean and dry. |
| Personal Care | Can wish, dress and feed self but with slight difficulties. | Some supervision or assistance required to wash, dress and feed self. | Assistance required to wash, dress and feed self over and above what is required for age. | Over 5 and total care required. No assistance from the child. |
| Safety & Supervision | Requires occasional supervision beyond that expected for that age. Poor sense of danger or risk of excitability. | Needing supervision to perform daily activities. Limited perception of danger to self or others. Requires supervision | Needs constant supervision during the day. Would place themselves or others at risk without supervision. | Needs constant supervision both day and night. No ability to perceive danger. |

| | | | | |
|---|---|---|---|---|
| | .Shoe1 | significantly greater than that expected for developmental age. | | |
| **Dimension** | **Mild** | **Moderate** | **Severe** | **Profound** |
| Behaviour & Social Integration | Some behaviour difficulties – mild, transient or frequent. Can be managed without special provision.<br><br>Able to sustain limited peer relationships and social integration with support. | Behaviour problems severe or frequent enough to require some specialist advice or provision.<br><br>Significant support required to achieve social integration. Only able to sustain peer relationships with support. | Long term behaviour difficulties, making it difficult for the child to function within their family or peer group most of the time, unless special provision is made.<br><br>Total dependence upon carer for social integration. Very limited awareness of impact of behaviour upon others. | Long term behaviour difficulties, affecting all aspects of the child's functioning. Frequent behaviour that may be of risk to the child or carers.<br><br>Complete isolation from peers and carers. No awareness of impact of behaviour upon others. |
| Learning Difficulty | Assessment shows abilities will achieve within 70 – 80% of the expected attainment for age. | Assessment shows abilities will achieve less than 70% or the expected attainment for age. | Assessment shows abilities will achieve less than 50% of the expected attainment for age. | Assessment shows abilities will achieve less than 35% of the expected attainment for age. |

## MASH COURT ORDERS FLOWCHART



## MASH PROCESS COURT ORDERS

**New Cases**

**LBH invited to be made party to another LA's Care Proceeding.**

Contact Officer will create a Contact on LCS and the court order to be uploaded in documents to the child's record.

The Contact Officer will ensure the referral follows the work flow informing the ISS duty Team Manager by sending an email to ISS duty TM/Court Proceedings Co-ordinator/Service Manager ISS/Senior Lawyer Legal Team.

**Open Cases**

The MASH Manager will follow the work flow and send the referral to the relevant service Team Manager on the case recording system and follow up with an email to TM/GM/Court Proceedings Co-ordinator.

**Closed Case**

**Request for s.7 Report**

On receiving a request for a S.7 report. The Contact Officer will create the contact and upload the court order in documents. The MASH Manager should then follow work flow and send the referral to the Assessment Duty Team Manager with a an email to the Assessment duty Team Manager /Court Proceedings Co-ordinator/ Assessment Team Service Manager.

**Request for s. 37**

On receipt of s.37 request. The Contact Officer should create the contact on LCS and court order should be uploaded in documents. The referral should be work flowed to MASH Decision Manager and should also be followed up with an email to ISS Duty Team Manager/Court Proceedings Co-ordinator/ISS Service Manager.

**Information Request**

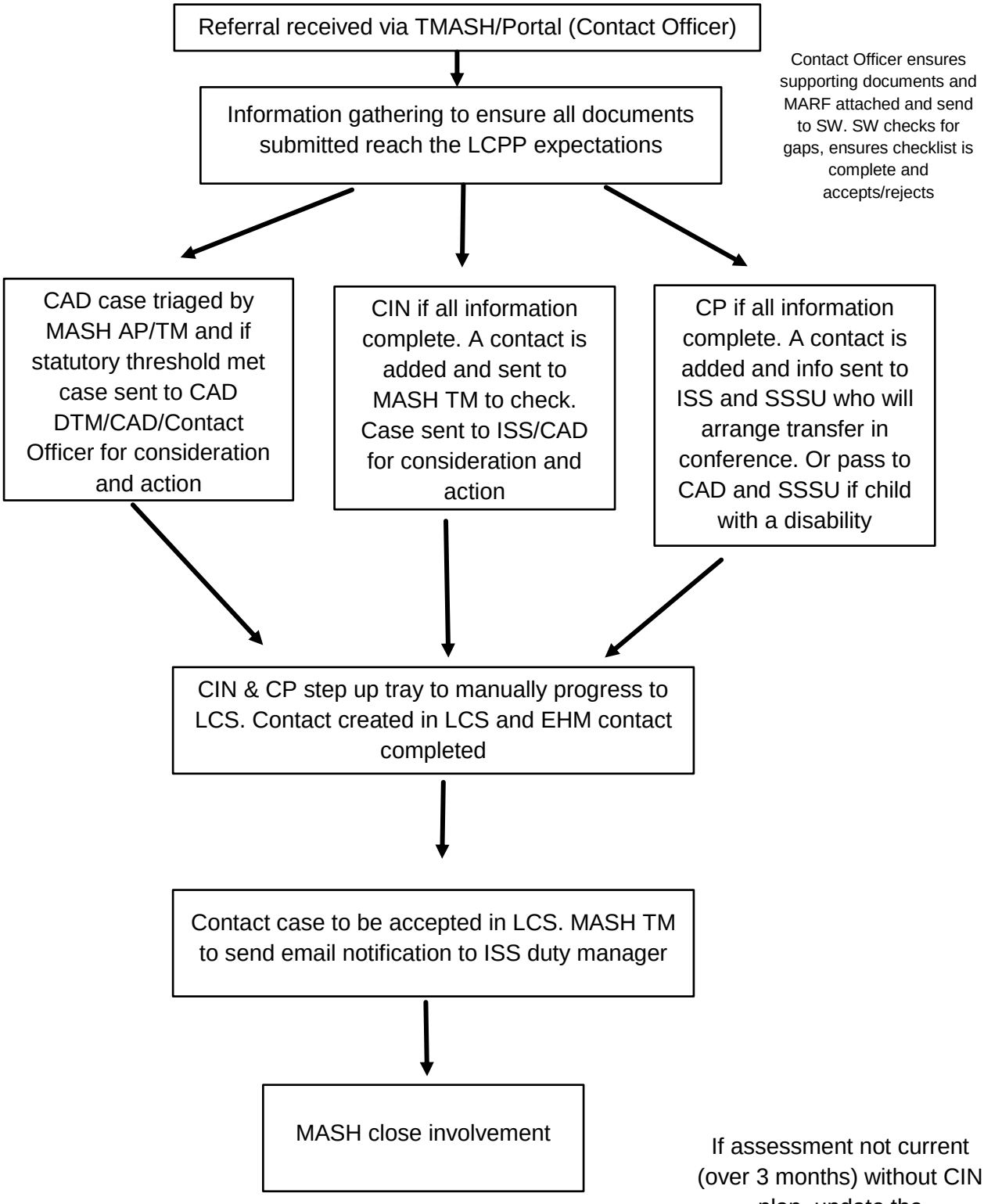
The Court directs LA to provide information on a child that LBH has had previous involvement. The court order to be sent to MASH Service Manager to review. The court order should be uploaded in documents.

MASH Manager to email court order to informationrequestchildren@havering.gov.uk and Court Proceedings Co-ordinator.

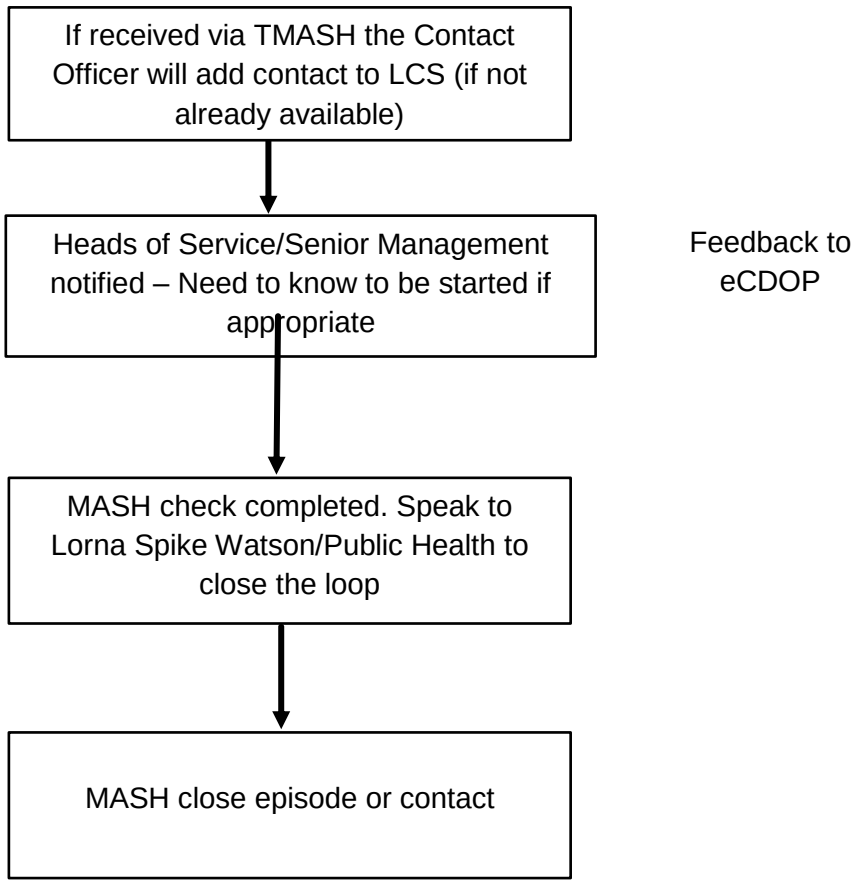
The Court Proceedings Co-ordinator will provide advice and support to MASH Duty Social Worker on what documents court should be provided.

MASH Duty Social Worker, will prepare and redact documents requested by the court. The documents to then be sent to the Court Proceedings Co-ordinator to have oversight of all the documents been sent to the court. On completion the documents should be forwarded to the MASH Team Manager who will send on to the court and close down the contact. The MASH manager to record in case notes the date the documents were sent to the court.

## TRANSFER IN PROCESS CIN/CP (FROM ANOTHER BOROUGH)



## NOTIFICATION OF CHILD DEATH (NOD)




MASH Duties:

- Contact received via email
- MASH to inform Strategic Heads of Services/Senior Management as required
- MASH TM will give task to MASH Duty SW to undertake checks
- MASH checks to be carried out with partner agencies
- MASH undertakes Checks and if open to services i.e. Assessment / ISS /CAD / EH will copy in the relevant HOS
- Needs to Know to be started for Head of Service

## MASH LADO PROCESS

LADO referral received into MASH

MASH TM triages referral and decides if a MASH SW should attend the LADO meeting or the assessment SW (dependent on concerns and whether it is likely the case will progress for an assessment). If concerns and statutory threshold met case progresses to referral for assessment. A STRAT will be arranged, chaired by the Assessment Team Manager with the LADO attending.

Referral will be forwarded to lado@havering.gov.uk cc. lisa.kennedy@havering.gov.uk and the Assessment TM will attend once the meeting is arranged (LADO will arrange meeting and send the invite directly to the Assessment TM.

*If Assessment TM **not** attending, referral to be forwarded to lado@havering.gov.uk cc. lisa.kennedy@havering.gov.uk*

MASH will create contact but only with initials of professionals or adults involved will be recorded (no full names). Contact to be closed down with outcome of: Referred to LADO. Give feedback to LADO re MASH contacting parents for sign posting and no need for them to attend. Ensure contact created has minimal info and child's info is not included on adults contact and vice versa.

LADO will send across actions to the Assessment TM who attended and tmash@havering.gov.uk.

The actions will be uploaded onto LCS.

The final outcome of the LADO process will be sent to MASH SW and tmash@havering.gov.uk for uploading onto LCS.

**MASH will upload any discussions/emails onto case notes to reflect accountability and actions.**

## HOMELESS/HOUSING PROCESS

**What are the different types of homelessness and next steps?**

Evicted from council, housing association or private rented accommodation:

- Families may have been evicted from their council, housing association or private rented property. In this instance families must make an approach to Housing Solutions. Children Services will only be involved in this stage if the reason for eviction is due to a high amount of rent arrears as it is likely that the housing assessment will uphold the eviction.

Intentionally Homeless:

- Families cannot be determined as intentionally homeless unless an assessment is completed by Housing Solutions. Intentionally homeless is when a family has done something or has not done something to secure their tenancy. This is usually whereby the family has been evicted due to rent arrears.

Housing duty ended:

- Where Housing Solutions have offered the family a suitable property and the family have declined to take up the offer of accommodation. Housing Solutions will end their involvement. Housing Solutions can end their involvement under this remit with immediate effect. Families are urged to take up the property. Many families decline for a number of their preferred reasons and should attempt to appeal the decision. This can also be done while in the accommodation. The appeal can be upheld by a reviewing officer from Housing Solutions. In most instances Housing Solutions will not make another offer of accommodation.

**Why are Housing not supporting the family?**

This occurs where Housing Solutions have no duty to the family as per above.

**What stage do Children Social Care get involved for a joint assessment?**

Evicted from council, housing association or private rented accommodation:

- Children Services will only be involved in this stage if the reason for eviction is due to a high amount of rent arrears as it is likely that the housing assessment will uphold the eviction. In this instance Housing Solutions will make a referral to Children Services to commence a joint assessment. Should Children Services be approached by another organisation or the family directly, they are to ensure that an application has been made to Housing Solutions.

Intentionally Homeless:

- Housing Solutions will ensure to make a referral to Children Services during the course of their assessment/investigation where there are concerns that the

reason for the approach brings about rent arrears concerns. Housing Solutions must not make a referral at the end of their assessment. Should this occur for any reason then a minimum of 28 days' notice is to be given and a referral to Children Services must be made when a 'minded to' letter is issued. This letter states to the family that Housing Solutions are likely to make an intentionally homeless decision and give the family 7-10 days to raise any additional information to plead their case.

- In this instance Children Services will seek to explore any parenting concerns around decisions made or actions not taken to ensure that children have accommodation and are not at risk of street homelessness.

Housing duty ended:

As Housing Solutions are only required to 'inform' the family of such a decision, this makes it challenging to complete a joint assessment. In such instances Children Services may be able to work with Housing Solutions to reconsider another offer of accommodation (case dependent) and should work with the family to understand the impact of their decision to decline a property and work with the family to reconsider

## HOMELESS FLOWCHART

**RAG AMBER**

Referral received from homeless team (Housing Solutions) 28 days prior to any eviction processes or decision outcomes

Contact opened on EHM (Contact Officer)

↓

MASH SW checks as appropriate and consultation with housing officer. Joint assessment to be completed at the front door

↓

Step up to Assessment Team if there is a need for a joint assessment between Housing and Childrens Services

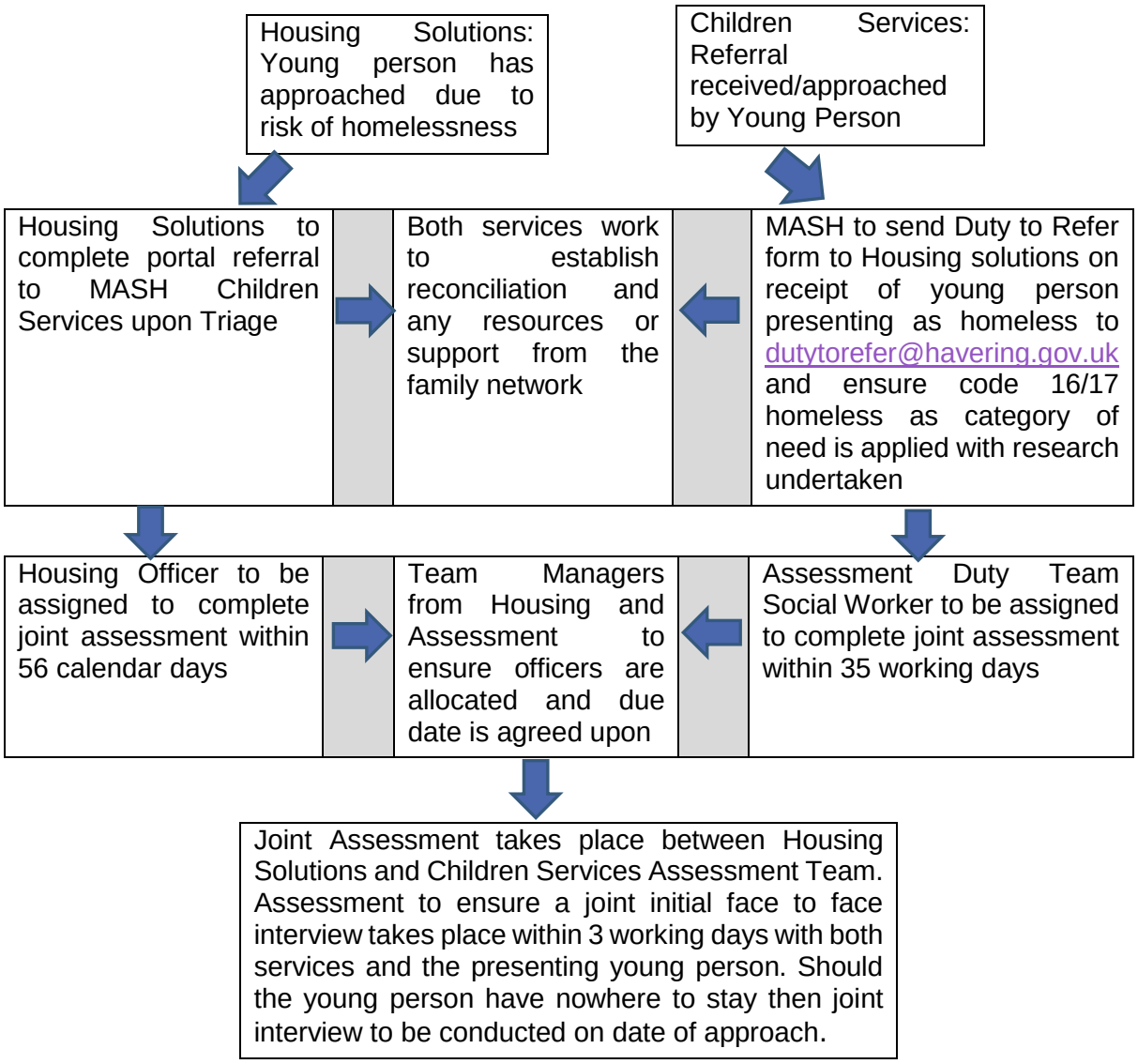
↓

MASH need clear understanding and detail in relation to any potential evictions and reasons for this based on housing involvement, including rent arrears amount, any letters that have been issued should be attached to the referral

Then with all information case to go to Assessment

Close working with housing officer as to the next steps and potential outcomes

## YOUNG PERSON 16/17 YEARS – HOMELESS APPROACH PATHWAY




The purpose of the assessment is to:

- Establish whether the young person is at risk of homelessness and establish any preventative processes such as residence with a family member or reintegration back into the family home.
- Establish the young person's ability to live independently and semi-independently.
- Identify any areas of concern and areas of support including but not exhaustive to mental health, education, employment/training, family conflict, ability to understand information, contextual safeguarding, concerns of missing and ability to meet self-care needs.

## USEFUL INFORMATION

Barnardos DA Risk Assessment

DASH Risk check list guidance

Criteria for a MARRAC referral

Concordat on Children in Custody

OOB Risk Assessment Template

CAADA young person 13-17yrs Risk Assessment

Brook Traffic Light Tool (2019)

Tool to assess an individual's vulnerabilities to potential radicalisation

Threshold Continuum of Need Matrix