

# exchange

Working together to keep children safe

## Editorial

Since the launch of *Exchange* last year, colleagues from local safeguarding children boards (LSCBs) have been keen to contribute their experiences and challenges in establishing new boards.

By sharing this learning we hope that partners in all jurisdictions will feel supported by their peers, and feel better equipped to take forward child safeguarding in their areas. Requests to contribute to *Exchange* have risen so significantly that we have doubled the size of the newsletter in order to meet this need.

On pages 4–6 of this issue we have given particular focus to the Child Death Overview processes. There is a commentary from a coroner, who was a member of the advisory committee to the Department for Education and Skills, on *Working Together to Safeguard Children* (2006), and also an account from the Metropolitan Police about a proposal to draw together processes across London's boroughs.

An update of developments in Wales and Northern Ireland provides an interesting three-nations' comparison in this debate. Other contributions to this issue include Merton LSCB's experience of consulting with young people in their collaboration towards the "stay safe" outcome.

**Sue Woolmore**  
LSCB Adviser, NSPCC

## Getting to grips with the wider remit



Photography by Paul Close, posed by models.

**LSCBs up and down the country are considering how best to embrace their developing role in safeguarding and promoting the welfare of children. New requirements set out in *Working Together to Safeguard Children* (2006) encourage boards to consider their role beyond the coordination of child protection services. The guidance states in paragraph 3.10: "Ensuring that work to protect children is properly coordinated and effective remains a key goal of LSCBs. However, when this core business is secure, LSCBs should go beyond it to work to their wider remit, which includes preventative work to avoid harm being suffered in the first place."**

The Merton LSCB in south London has considered the implications of this "wider remit" and has responded with a

somewhat cautious approach. Andrew Wyatt, safeguards service manager, said: "When we first noted that LSCBs are expected to embrace a 'wider remit' on preventing harm, I guess we took a big step back. Firstly, the Crime and Disorder Partnership and Drug Action team, Safer Merton, already takes the lead, locally, for developing and implementing strategies to reduce crime, anti-social behaviour and substance misuse, and is addressing many of the wider safeguarding issues. Secondly, our considered approach is very clear – child protection must remain our core business. That is not to say the LSCB should not have an interest in initiatives that are expected to prevent harm and ultimately reduce stresses on children, their families and communities."

**Continued on page 2**

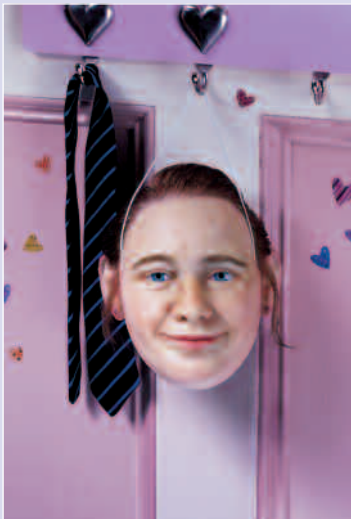
## Getting to grips with the wider remit (continued from page 1)

During autumn 2006 several meetings took place involving partner agencies that have a stake in the broad range of children's safeguarding issues, including community safety, road safety, education inclusion, youth justice, and drug and alcohol services. The first task was to identify the lessons learned from the Children and Young People's Plan, developed following extensive consultation with children and young people. For example, children and young people wanted bullying and the fear of bullying to be tackled. Safety in parks, on buses and getting home from school also featured highly.

Andrew Wyatt went on to say: "Rather than starting from scratch, we decided to explore where the LSCBs' interests overlap with the Children and Young People's Plan and then began to steer further discussion to address any gaps. Our next stage has been to find out what each agency is doing to protect children – using 18 key themes – including road safety, domestic violence, bullying, self-harm and mobile phone safety.

This sort of information has never been drawn together locally for planning purposes. We actually do not see LSCBs leading on many of the broader safeguarding issues, as these are already covered within the local community safety initiatives. We now think we will have a real opportunity to be better joined up across child protection services and the wider safeguarding agenda."

For more information regarding Merton LSCB's approach, please contact Howard Baines, safeguarding development officer for Merton, on 020 8545 3801, or email [howard.baines@merton.gov.uk](mailto:howard.baines@merton.gov.uk)



## Don't hide it

**Christopher Cloke, head of Child Protection Awareness at the NSPCC, discusses the *Don't hide it* campaign.**

In spring 2006 the NSPCC launched the *Don't hide it* campaign, focusing specifically on sexual abuse, using the message: "You don't have to hide it any more." Carefully targeted youth media was used to empower children and young people to speak out.

As many LSCBs were keen to engage with this campaign, it seems helpful to provide some feedback on how it progressed.

Disclosing abuse is a very difficult process, and it would have been unrealistic to only ask young people to phone ChildLine. Children need to be shown that there are other less challenging ways of speaking out, which in turn can help them build the confidence they need to report the abuse. Therefore, young people were offered safe places where they could both hear about the experiences of others, and speak out about their own experiences in ways familiar and comfortable to them.

The use of space on the Bebo website was particularly positive in providing young people with easy access to support and advice. The typical length of stay on the site was above average – between four and six minutes. Video material on the site was viewed 600,000 times, with the story of the young girl who was raped after meeting a man she had spoken to in a chat room being by far the most visited. On the advice section of the site, 160,000 pieces of advice were accessed. The most viewed piece was: "What should I do if I'm worried."

The spring 2007 *Don't hide it* campaign is broadening the focus for young people to being abused in all forms, rather than just sexual abuse. It will also be publishing materials for 8 to 11-year-olds.

Christopher Cloke is head of the NSPCC's Child Protection Awareness and Diversity department. He plays a key role in developing the safeguarding messages promoted by the Society, including its communication to professional and public audiences.

**If your LSCB would like to get involved with the NSPCC in communicating these messages to the young people in your area, please speak to the NSPCC representative on your board or contact Sue Woolmore, LSCB adviser, whose contact details are on page 8.**



## It's good to talk

**To help and encourage LSCBs to share good practice, the Department for Education and Skills (DfES) has launched a new LSCB forum. This will allow those involved in LSCBs to talk directly to each other about problems they may be facing and possible solutions, as well as share what they are doing and seek advice from others.**

In addition, the DfES will provide links to supplementary advice, including more structured case studies about LSCB work, how LSCBs have managed the need for investment of resources, both financial and human, and how they have sought to contribute to the wider goals of improving the wellbeing of all children, while still maintaining a particular focus on the core business of staying safe.

The main sections of the new *Working Together to Safeguard Children* published in April came into force in October 2006. LSCBs are expected to implement this through their policies and procedures. The forum is one of the tools that will enable LSCBs to achieve this effectively by providing an efficient way of creating networks and links across the country.

If you would like to be set up as a member of the forum or if you have any comments or suggestions on how it can be improved, please contact Terry Hegarty at [terry.hegarty@dfes.gsi.gov.uk](mailto:terry.hegarty@dfes.gsi.gov.uk)

# A step in the right direction

Alison Roe discusses West Berkshire Council's new model for conducting child protection conferences.

In 2005, West Berkshire Council designed and implemented a new model for conducting child protection conferences. The *Strengthening Families* framework is based on principles of solution-focused therapy and builds on earlier work by A Turnell ("Aspiring to Partnership; the Signs of Safety Approach to Child Protection"; *Child Abuse Review*, 1997), and S Lohrbach and R Sawyer ("Advancing Partnership-Based Practice with Families"; *American Humane Association*, 2004).

The main aim of the model is to develop stronger partnerships between families and professionals

The main aim of the model is to develop stronger partnerships between families and professionals. It promotes the greater involvement of families in conferences and ensures that participants get a balanced picture of the strengths within a family, as well as the presenting risks. The model consists of the following broad stages:

- Introductions and an ice-breaker session in which the family helps to create its own genogram (an extended family tree) on a whiteboard at the front of the room.
- An information-sharing session in which families, as well as professionals, are encouraged to share information and views, and in which the *Strengthening Families* framework is completed under five headings: danger/unmet needs, risk statements, complicating factors, strengths/protective factors, and grey areas.
- Development of a plan outlining the next steps and actions needed in order to ensure sufficient safety for case closure. Responsibility and timescales for each of these actions is documented.

An evaluation of the model after one year of operation has recently been completed by West Berkshire Council. Interviews have been carried out with families and professionals who attended the new-style conference. Although there are still areas for improvement, the results of this evaluation suggest that the *Strengthening Families* framework is a step in the right direction.

## Get the latest child protection news from CASPAR

CASPAR News (Current Awareness Service for Practice, Policy and Research) is a free online and email service from the NSPCC Library and Information Service, which keeps professionals and practitioners working with children up-to-date with key developments in the world of childcare and child protection.

Register for free, weekly CASPAR email alerts on the NSPCC Inform website at [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform)



Photography by Paul Close, posed by models

Professionals who have attended the conferences are generally enthusiastic about the new approach. They describe it as more objective, more evidence-based and therefore fairer to the family. They find the structure provided by the model helpful and are positive about the use of a visual tool within the conference. They report wider involvement of professionals in all aspects, and greater contribution from families in the information-sharing stage (although not yet at the planning stage). They feel that conferences following the new model are less intimidating and therefore help to maintain good relationships with families. Most families interviewed as part of the evaluation said that they felt respected and involved in the conference.

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They were able to recognise and appreciate the positive feedback provided by professionals. They were also aware of the various goals emerging from the conference and therefore aware of what was required of them in terms of change. The families did, however, still require greater involvement and wanted support in producing a written report of their own in advance of the conference. They were also able to identify a range of professional behaviours and service practices that, if not addressed, could undermine what appears to be an effective model for partnership working.

Alison Roe works with West Berkshire Children's Services, providing evaluation and feedback to managers on how their services are operating, and making recommendations for change.

**For further information or a copy of the full evaluation report, *A Step in the Right Direction*, please contact Alison Roe, research and information manager on 01635 519732 or email [aroe@westberks.gov.uk](mailto:aroe@westberks.gov.uk)**

# Dealing with child deaths

*Working Together to Safeguard Children (2006)* describes the new responsibility placed on LSCBs in England from 1 April 2008 to review all child deaths in their areas. There must be two interrelated processes: a rapid response by a group of key professionals for inquiring into each unexpected child death, and an overview of all child deaths (under 18 years) undertaken by a panel. *Exchange* has invited contributions from different disciplines to comment on the new guidance.

## Under resourcing: the ultimate travesty

### Coroner John Pollard comments on the development of child death overview processes.

It is the duty of the coroner to investigate all deaths reported to him/her and – when the cause of death is unknown or sudden, violent or unnatural – to hold an inquest.

### The child's body has to be transported a great distance to a tertiary centre

In the majority of child deaths the cause is unknown, and a special paediatric post-mortem examination should take place. In Greater Manchester we are lucky to have two very able paediatric pathologists, yet they are working to their limit. In many other parts of the country there are no paediatric pathologists, and therefore post-mortem examinations are either performed by non-specialist pathologists (which is unsatisfactory), or the child's body has to be transported a great distance to a tertiary centre. Again, this is unsatisfactory, and often technically unlawful because a body should only be removed to an adjoining jurisdiction.

### An agreed protocol

In every coroner's jurisdiction there should be in place an agreed protocol for the examination and investigation of child deaths. This should include full provision for Her Majesty's Coroners to be notified immediately of the death, HM's Coroner's investigation team (civilian and/or police) to attend the scene and commence inquiries, a community paediatrician to carry out a home visit, and all immediate post-mortem samples to be collected. In reality, because of the wholly inadequate

resourcing, much of this simply does not happen in many cases. There are few community paediatricians in the country with the time available to carry out this additional duty. In many areas the coroner has neither the time nor the expert assistance to embark on the speedy, efficient, yet caring inquiry that is so necessary in these cases.

Added to all the above is the recent guidance referring to Child Death Overview Teams – *Working Together to Safeguard Children (2006)*. I was a member of the team that drafted the guidance, and it was the expressed intention of all involved (legal, health and government representatives) that the whole investigation be on a teamwork basis. The coroner should be the leading member of the team, and should be able to attend either in person, or should be represented by his/her officer at all the review meetings.

### In many areas the coroner has neither the time nor the expert assistance to embark on a speedy inquiry

It is simply not possible for this to happen in busy coroners' jurisdictions. Neither the coroners, nor the staff, have time to attend these meetings, and extra resources will have to be made available to enable this to occur.

### In need of reform

The coroners' service has been the Cinderella of the judicial world for many years. It operates on a financial shoestring, and the powers and working methods of HM's Coroners are in many ways outdated and in need of reform.

A draft Coroner Reform Bill was recently published by the Government, but this was so unsatisfactory that it was severely criticised by the select committee of the House of Commons, by the Coroners' Society, by the Royal College of Pathologists, Victims' Voice and many others, and was omitted from the Queen's speech.

The aim of the modern coroner is to carry out a "full and fearless" investigation as an independent judicial officer, while at the same time being caring and extremely mindful of the needs of bereaved relatives. Nowhere is this more necessary or important than when dealing with the death of a child.

### Unless the coroners' service is properly funded, there is no way in which coroners will be able to work effectively with the overview teams to prevent future child deaths

Unless the coroners' service is properly funded and modernised there is no way in which coroners, however well-intentioned, will be able to work effectively and consistently with the overview teams to try to prevent future child deaths. It is the ultimate travesty that under-resourcing, both human and financial, is allowing preventable child deaths to continue to happen.

**John Pollard is a coroner based in Greater Manchester South. He was a member of Baroness Helena Kennedy's working group on sudden infant death and was also a member of the advisory committee to the Department for Education and Skills on *Working Together to Safeguard Children (2006)*.**

# A paediatric perspective

**Chris Hobbs discusses the implications involved in the new Child Death Review processes.**

Child death is thankfully uncommon. A child's death may be predicted, but many are sudden and unexpected. Undoubtedly some deaths (unnatural) follow acts of commission or omission on the part of parents. Following models in other countries, including the USA, a new child death review process is being introduced into UK practice. The inclusion of this process into the *Working Together to Safeguard Children* guidance reflects an acknowledgment of the relationship between many child deaths and childhood abuse and neglect. Obvious deaths due to abuse are the tip of the iceberg.

An understanding of the causes and antecedents of child death requires more than a pathological study of the body.

## The causes of child death require more than a pathological study of the body

The guidance on Child Death Overview processes has at its basis the findings of the Kennedy Working Party, convened after three high-profile infant death prosecutions failed. The model for the investigation of unexpected deaths, many of which occur in infancy, follows closely that developed by Fleming and colleagues, whose work in this area is well known. The emphasis is on multi-agency cooperation and communication.

Why the new guidance? A "too late to do anything" response must be replaced by "what could have reduced the chance of this happening", or "how could this have been prevented". Society needs to know why children die and whether deaths could have been prevented.

Paediatricians, for whom the guidance has included more responsibilities, are unsure of the new active role. The model of an immediate joint home visit by a health professional and the police may be uncomfortable for many doctors. It is, not surprisingly, meeting resistance. A doctor may ask: "How would I know what to look for? What would I do? I am not a detective, I am a doctor."

An experienced nurse or health visitor might obtain more

information, but it would not be the same as that obtained by a doctor. Whatever happens in practice, it is clear the police must not be left to make inquiries alone. A designated paediatrician will also be required to coordinate and advise this part of the process. A number of PCT areas may have to combine to support such a professional. The supply of doctors to do this job may not initially meet demand.

Obtaining quality systematically acquired information will require professionally trained people (there is a course at Warwick University). There will be a need for specialists who can cope with the anguish of death, who can support parents and pursue objective inquiries even if acknowledging at the same time that parents may have actively or passively played a part in the child's death.

Getting all the professionals together at a case meeting when a full post-mortem result is available is a vital part of the process. This meeting should enable a picture to be drawn of the child's life and death and should provide an opportunity for professionals to learn lessons and allow the case to be laid to rest.

Supportive chairing will be needed to aid information sharing in an open and honest way, without blame or judgement of family or professionals. Information from this meeting will need to be fed back to the family (another challenge for the paediatrician), the coroner and the review panel of the LSCB.

The second part of the review involves the LSCB in an overview panel composed of senior

## Poverty and social exclusion remain the most consistent factors in child death

professionals. They will have an equally demanding role in translating the information from the case reviews, both individually and collectively, into the safeguarding agenda. Poverty and social exclusion remain the most consistent factors in child death. A new process has been needed for some time. Hopefully, manpower resources (including paediatric pathologists) will be available to enable this far-reaching process to work as intended.

**Chris Hobbs is a consultant paediatrician at St James's University Hospital, Leeds.**

# Regional protocol for Northern Ireland

**In December 2006, the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland carried out a consultation exercise into procedure guidelines in cases of sudden unexpected child deaths.**

The death of any child is a tragedy. When that death occurs suddenly or unexpectedly a number of different agencies and disciplines will become involved to try to establish the cause of the death and to support the bereaved family. The Regional Child Death Review Protocol (the Regional Protocol) recommends a multi-agency approach. This operational document outlines the responsibilities of statutory agencies and professional staff when dealing with the sudden or unexpected death of any child from birth up to the age of 18, whether that death occurs at home, in a community setting (including any educational, care, secure care or custodial setting), or in hospital. It requires that, at a very early stage after the child's death, the professionals who have been involved with the child/family meet and share information about the child, including details about the death and other circumstances.

A case management review report in Northern Ireland (equivalent to serious case reviews in England and Wales) following the death of David Briggs – a child adopted in Romania by Mr and Mrs G Briggs – recommended a multi-agency approach be used in cases of sudden unexpected child death. The Lewis Report, commissioned by the then minister for Health, Social Services and Public Safety after the Briggs case, endorsed this recommendation. In addition to the impetus given by the Briggs case management review of the need to develop a protocol for the investigation of child deaths, a number of national and regional publications have highlighted the crucial importance of such an initiative.

The draft Regional Protocol takes account of best practice and recommended procedures arising from the most recent developments in policy and research within this area of expertise. It builds upon the work of a draft protocol developed by a working group established under the auspices of the Southern Health and Social Services Board's Area Child Protection Committee, which was submitted to the DHSSPS to be progressed as a Regional Protocol.

The DHSSPS will shortly consult on the establishment of a new regional safeguarding board for Northern Ireland (SBNI), which will replace the four existing Area Child Protection Committees. The department recognises that there is a need for analysis of the information arising from sudden or unexpected child death, and it is possible that this may be a role for the new regional SBNI.

**Isobel Riddell, deputy principal, Childcare Policy Directorate, DHSSPS**

# Child death reviews in London

### Detective Chief Inspector Richard Henson examines the child death overview process from a police perspective.

When new legislation requires agencies to work together in significant new areas without new funding or instructions, it can be considered an opportunity or a threat.

### It is no simple task for London LSCBs to complete the task of establishing child death overview panels effectively

This situation has arisen under the Children Act 2004 for LSCBs, in relation to the requirement to establish child death overview panels.

*Working Together to Safeguard Children* (2006) offers some guidance as to what is expected, but has not provided a template for implementation. Without being prescriptive, the guidance does suggest that neighbouring LSCBs may decide to collaborate on this matter. However, in many ways these are uncharted waters for LSCBs, as their size and resources vary, and each has its own unique identity.

There are 32 LSCBs in London, but none has the recommended 500,000 minimum population size for the establishment of an overview panel. The capital is hugely complex: its population is 7.2 million, with 1.7 million under the age of 18, not including visitors. Social care and the provision of education are largely delivered on a borough basis. Health provision is complex, with various trusts and health authorities overlapping, but not necessarily sharing borders with boroughs. London is served mainly by the Metropolitan Police. In addition, there is a host of voluntary and non-government organisations, and seven coronial areas. The contiguous boundaries of boroughs in small geographical areas encourage residents to frequently cross boundaries for recreation, education, medical and social reasons.

Therefore, it is no simple matter for London LSCBs to complete the task of establishing child death overview panels effectively.

### Project Indigo

Against this background, the Metropolitan Police Child Abuse Investigation Command has promoted an initiative through Project Indigo to respond to all cases of Sudden Unexpected Infant Death (SUDI). Project Indigo applies to SUDI in children below the age of two. It coordinates an investigative partnership, following recent recommendations into best practice contained within the Baroness Kennedy report on SUDI.

Since April 2005, specially trained detectives in London have delivered a standardised operational approach to SUDI, ensuring appropriate information exchange, the prompt engagement of other professionals, support for families and accurate recording

### Data analysis will continue to develop further to assist in positive support and campaigns that will reduce the risk of the untimely death of children

of data with a consistent and controlled methodology.

Database analysis of all cases of SUDI since April 2005 has already commenced, and will continue to develop further to assist in positive support and campaigns that will reduce the risk

of the untimely death of children. The natural extension of this work is to apply the best practice around rapid response, partnership working and data analysis beyond SUDI.

Work is underway to find a cost-effective and efficient method of delivering a high-quality and consistent response to child deaths in London. The two distinct functions of this process are rapid response and overview panels.

### Centralising coordination

It is generally accepted that rapid response is best coordinated and delivered at a local level. This is because most social care and medical services are currently arranged and delivered on this basis, and LSCBs are in a position to ensure that these are effective.

### Positive support from a large number of stakeholders has been forthcoming and a pilot is being planned for seven north London boroughs in early 2007

In relation to child death overview panels, the Metropolitan Police have submitted a proposal to organise London into four sub-regions. This will mean centralised coordination, but will use specialists from constituent LSCBs who will meet on a quarterly basis to review cases on behalf of their LSCBs within a common framework. The product of these panels will then be collated and reports prepared for each LSCB, each sub-region and London as a whole.

Work is still very much in progress, but with just over a year to go, positive support from many stakeholders has been forthcoming and a pilot is being planned for seven north London boroughs in early 2007.

Detective Chief Inspector Richard Henson works within the Specialist Crime Directorate, Child Abuse Investigation Command of the Metropolitan Police. He has worked closely on Project Indigo, which has helped to inform the proposals for child death overview processes in London.

**Please contact [richard.henson@met.police.uk](mailto:richard.henson@met.police.uk) for more information.**

## Child death reviews in Wales

**The Welsh Assembly Government has proposed that an all-Wales model be developed, rather than the English model, with each LSCB having the function of setting up Child Death Overview panels. LSCBs in Wales will still have the responsibility to carry out serious case reviews.**

The Welsh Assembly Government has asked the National Public Health Service to lead the piece of work looking at developing a Welsh model. This work is in its early stages and questions of how an all-Wales panel will relate to the Welsh Assembly Government and the 22 LSCBs in Wales is one of the questions that needs to be resolved.

# Public protection



Megan Kanka, who was killed in 1994 by a known sex offender in her area

The link between LSCBs and multi-agency public protection arrangements (MAPPAs) is a crucial one. The NSPCC has published *Megan's Law: does it protect children? (2)*, a policy research report which examines the effectiveness of Megan's Law in the United States. The study updates the NSPCC's 2001 report on this subject and examines

whether Megan's Law can deliver tangible safety benefits for children. It also evaluates the legal, practical and ethical issues associated with community notification of sex offenders.

The paper is intended to help policymakers and practitioners develop an informed position on the subject of public access to information about convicted sex offenders. It includes an examination of the potential for offenders to "go underground" in response to increased surveillance, the possibility of vigilantism, the impact on parents and children, and the financial costs associated with the laws. It also stresses the need to focus more attention on intra-familial abuse, which is more common than attacks on children by strangers.

The research has found that there is currently insufficient proof that the community notification practices of Megan's Law make children safer. Registration and notification alone cannot solve the problem of child sexual abuse. Policymakers should ensure that sex offender management policies are based on objective evidence of what makes children safer and not on popular responses to high-profile sex crimes.

To download the executive summary and the full report, please visit [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform)

## Helping children and young people through the court

**The NSPCC's *Power pack* provides information and guidance for children and young people with cases in the family courts. It was produced in consultation with children and young people and includes sections on words and meanings, the court, children's guardians, children's solicitors and children's rights.**

*Power pack* is available in several versions, including one aimed at young children, and another at older young people. It is also available in DVD format – in British Sign Language, with audio and subtitles – for deaf and disabled children.

In addition, there is an easy-read version for children and young people with learning difficulties, including guidance notes and information about communication for anyone helping these children. This can be downloaded free from [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform)

To order copies of the *Power pack*, please visit [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform) or call 020 7825 7422, or email [publications@nspcc.org.uk](mailto:publications@nspcc.org.uk)

# Supporting young runaways



Photography by Jon Challicorn, posed by a model.

**Each year 100,000 young people under the age of 16 run away overnight in the UK, a quarter of whom are under 11. Repeated running away is particularly destructive – it can lead to an increased risk of abuse and exploitation, and involvement in criminal activity, prostitution or substance misuse. A research project, run in partnership between St Christopher's Fellowship and the NSPCC, has gathered the views of young people from the London Refuge for Runaway Children, their parents and professionals involved in supporting runaways.**

*Beyond refuge* reveals the findings of the research and focuses on why young people leave home and the range of support services available for those who return to their families. The report suggests innovative ways in which policy could be better attuned to meet the needs of young people and their families in the future.

To order copies of *Beyond refuge*, please visit [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform) or call 020 7825 7422, or email [publications@nspcc.org.uk](mailto:publications@nspcc.org.uk)

## Contribute to Exchange

The NSPCC welcomes contributions and comments for *Exchange* from colleagues and partners working on LSCBs and ACPCs (NI). This is an effective way of sharing learning, while also providing a platform for debate and analysis of issues facing all those committed to safeguarding children and young people.

If you would like to contribute to a future issue of *Exchange*, please contact Sue Woolmore, who will welcome a discussion with you (see page 8 for contact details).

# Making the links

**Fiona Becker explores the connections between dealing with animal cruelty and safeguarding children.**

The drive to make child protection everybody's business has relevance to animal welfare professionals, since they regularly come into contact with families through home visits and at veterinary practices. Consequently some LSCBs have started to recognise the need to engage with these professionals. By way of context, in 2002 there were 114,000 investigations into animal cruelty by the RSPCA, from which there were 910 prosecutions. Fifteen of these were of children who had abused animals (RSPCA, 2003).

LSCBs will want to consider the implications of the growing evidence base that seeks to explore the links between how animals are treated and the abuse of children and women. Research has highlighted four broad themes:

- Animal abuse may be part of a continuum of abuse within the family. In the context of domestic violence, acts of animal abuse are used in order to coerce, control and intimidate children and women to remain in, or be silent about, abusive situations.
- Animal abuse perpetrated by children may link to later aggressive and criminal behaviour.
- Animal abuse may be an indicator of the existence of child abuse.
- The human-animal bond can be very important in child-development terms and has been linked to enhancing resilience. It is also used proactively within post-abuse work in the USA.

There are several limitations with the current research, but it does indicate that there are correlations between children abusing animals and children harming people, and between adults abusing animals and adults abusing family members.

Developments are taking place to take account of these correlations. For example: the growth in pet fostering services for families escaping domestic violence, training for veterinary students and RSPCA student inspectors, and a revised professional code of practice for veterinary surgeons, which permits them to share child protection concerns encountered in their work.

Given these developments it is timely for LSCBs to consider:

- What kinds of local links exist between child safeguarding and animal welfare services?
- Are animal welfare professionals included in local multi-agency child safeguarding training?
- Do local services for domestic abuse have links with pet fostering schemes?
- Do assessments of children integrate questions about the significance and treatment of family pets?

To download *Understanding the Links: Child Abuse, Animal Abuse and Domestic Violence*, please visit [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform)

A conference organised by the Links multi-agency working group will be held on 16 May 2007 in Uxbridge to explore relevant legislation, research and practice developments in this field. This will be open to child safeguarding and animal welfare professionals. To request further details, please email [linkssecretary@aol.com](mailto:linkssecretary@aol.com)

**Fiona Becker is a senior consultant within the NSPCC Consultancy Service. Following a joint conference between the NSPCC and the RSPCA in 2001, she became part of an external group seeking to take this issue forward.**

**For further information, please contact Fiona at [fbecker@nspcc.org.uk](mailto:fbecker@nspcc.org.uk)**



Photography by Andrew Olney, posed by models.

## Looking for forthcoming safeguarding conferences and events?

Our free weekly email alerts keep you up-to-date with all the latest news about forthcoming child protection conferences and other events for professionals working to safeguard children.

Register online to receive regular information about future events covering all aspects of child abuse, child protection and child welfare planned by a wide range of organisations.

Are you organising a conference or event? Email [inform@nspcc.org.uk](mailto:inform@nspcc.org.uk) if you would like us to promote your event to a professional audience. To sign up, visit NSPCC Inform at [www.nspcc.org.uk/inform](http://www.nspcc.org.uk/inform)

To discuss the NSPCC's contribution to your LSCB or ACPC please contact:

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**NSPCC**  
Cruelty to children must stop. FULL STOP.