Rotherham Safeguarding Children Partnership

Strategy Discussion Checklist

It is important that we are systematic in our approach to managing and recording strategy discussions and meetings. This template provides a basic structure that will ensure all key requirements of a strategy discussion are completed.

1. Child basic details (including ethnicity)
2. Parents / Adult details
3. Date of Strategy Discussion / Meeting
4. Agencies and name of service involved in this Strategy Discussion / Meeting
5. Apologies given for this Meeting
6. Reason for this Strategy Discussion / Meeting
7. Parental Involvement / Awareness
8. Information Sharing and Discussion in relation to risk
9. Decision and Actions

NB Is the meeting compliant with Working Together (2018) - Police/Social Care/Health representatives?

A. What are the risks to this child/children?

This is about using the Multi-Agency Threshold descriptors to support setting the context, providing a narrative but being clear regarding the risks. It is important to list the risks and give reasons. Consider each child in their own right. All attendees' views should be clearly recorded – it is also important to be specific; do not generalise.

a) Who is worried?

b) What are they worried about?

   i. Give details of the first, last and worst example of the behaviour causing the worry

   ii. What is the impact of the behaviour on the child/ren?

c) What is the likely impact on the child/ren if nothing changes?

d) Are there any other children that need to be considered?

e) What service response level do the risks currently map on the Threshold descriptors?

B. Is there need for immediate supportive, protective or legal action?

a) Agree a scaling question among the attendees which will help you understand the risk to the child/ren TODAY – i.e. a scaling question unique to the family and circumstances. An example might be:
On a scale of 0 to 10, where 10 is that the child/ren are as safe today as they were yesterday and the interim safety plan will ensure the child/ren will be safe enough until we have a chance to assess the situation properly, and 0 is that the risks to the child/ren are so great that we need to take immediate action to remove the children to somewhere else, where would you (every attendee) scale each child today?

b) What form of action is to be taken, why is that action being taken? Include by whom and when.
If child/ren are to be removed from their current living circumstances, try to identify someone in the network of naturally connected people who can care for the children immediately with the least disruption to their

lives, including school and friendships. The interim person might be the child's best friend's parents or other person outside the immediate family but where they have stayed before. Placement should be agreed with parent/s and child/ren if they are of age and understanding to have their wishes taken into consideration.

C. Using the Multi-Agency Threshold descriptors to support decision making is the threshold for significant harm met and S47 Enquiries undertaken as part of a Child's Assessment?

Provide specific individual agency reasoning/rationale/evidence for threshold of significant harm being met or not met. It is not good enough simply to state it has or has not been met without providing a rationale and evidence. Re-consider the questions in Section A (Who's worried, what are they worried etc)

D. Does there need to be a Child's Assessment under S17 of the Children Act?

If so, identify who will complete. Multi-agency threshold descriptors will support rationale for decision making to proceed under S17. Ensure a genogram is to be completed early and family network considered.

E. Lower threshold response

If a lower threshold response is required, please provide the reasons/rationale for decision making – does the use of Multi-agency threshold descriptors support the case to be stepped down to Early Help or managed in Universal services?

F. Does the child need a Child Protection Medical? Consider SARC referral if risks are related to Sexual abuse/assault. Consider CAMHS referral if risks are related to the child's mental health or emotional wellbeing (e.g. the child is making suicidal statements or considered at risk of mental health crisis). If a medical has already been undertaken what are the findings?

If not when will this be arranged? Consider any logistical barriers including who should accompany child/ren. Ensure consent for the medical is obtained at the earliest opportunity to prevent delay. Ensure that lead social worker coordinates the arrangements for medical via the on-call Paediatric registrar. If any concerns regarding timeliness of the medical escalate to Paediatric Consultant on duty. Consider siblings and other significant children in the household and their need for Child Protection Medical.

G. Does there need to be a Police Investigation?

Is this going to be a single or joint investigation? Who will / may need to be interviewed? What evidence is required and what is the timing of the investigation? Is an Achieving Best Evidence interview required of the child? What needs to be in the Child Interview Plan? Please make reference to joint investigation protocol document (appendix) to support decision making.

H. Is there any other information required and from whom?

For example, significant other adults, older siblings, other professionals, other people who are naturally connected to the family. Consult previous genograms / family networks if available. Clarify who else needs to be subject to strategy discussion and ensure that they are discussed within own right.

I. Does there need to be a referral to any other agency?

If so – who, why, what, where and when?

J. What is the extent of the parent's awareness of the situation and do they need to be engaged at this stage and by whom? Record when the parents will be informed of the decision of the strategy meeting.

If not seeking parental consent, please evidence reasoning and ensure follow current protocol – seek legal advice.

K. Do the parents or any other adults require restrictions on contact with or care of the children?

How will this be achieved – agree an interim safety plan. Agree who will work with the parents to create this ideally using Words & Pics so that it can be shared with the children. Ensure a clear plan regarding any contact/supervision restrictions are shared to Health if the child is an inpatient in Hospital.

L. Is there anything that needs to be communicated to the child / young person?

Who is best placed to do this?

M. Is a further Strategy Discussion / Meeting required?

N. What is the agreed safety plan from today through to ICPC or conclusion of s47?

Action Plan – Agreed actions should be recapped at the end of the meeting (prior to full minutes being shared). All attendees should ensure they leave the meeting with a copy of actions.

SMART actions to be taken	By Whom	Date for completion

Appendix 1 Joint Investigation Protocol Guidance

The criteria for conducting a joint investigation of a referral of alleged/suspected child abuse is the likelihood that a criminal offence may have been committed NB the likelihood of prosecution is not a factor).

There is often no clear answer as to whether joint investigation should be pursued – in such cases, this needs to be discussed and challenged between agencies as necessary and appropriate and decisions accurately captured within the minutes of the strategy discussion/meeting.

Subject to discussion, the following circumstances *may* result in a joint Police and Social Work investigation:

- Actual or suspected serious physical injury or neglect.
- Abandonment of young or vulnerable children where the child is exposed to danger.
- Violence to a child constituting an assault, actual or grievous bodily harm, marks, bruising, or soft tissue injuries to babies or very young children.
- Sexual abuse; including penetrative sexual abuse and allegations of harm arising from underage sexual activity (for example, peer on peer abuse).
- Where the alleged perpetrator (who is in a position of trust) has unsupervised access to a child or children, e.g. voluntary group leader, teacher or medical nursing professionals.
- Allegations or reasonable suspicions that a criminal offence has been committed.
- Allegations of reasonable suspicion of serios neglect which may require action under Section 1 of the Children and Young Persons Act 1933.
- Significant concerns about the welfare of an unborn baby.
- Bullying that is leading to a risk of significant harm.
- Allegations or reasonable suspicions which involve unusual or specific circumstances e.g. organised or institutional abuse or medical conditions such as fabricated or induced illness.

Please note this list is for guidance, and professional judgement and discussion should be employed in line with the individual circumstances for the child(ren) being discussed.