CHAPTER 5

Protecting children

In the previous chapter we discussed the meaning of prevention in the context of the Children Act 1989, and we looked at a few of the family-support services designed to prevent abuse from occurring. In this chapter, we shall focus on protection: that is, what happens when abuse or neglect are alleged or have actually occurred.

Objectives

When you have read this chapter, you should understand why agreed definitions of child abuse are so important and why figures on child protection registers fail to reflect the true extent of child abuse. You will encounter a number of perspectives on the causes of abuse, and the consequences of both physical abuse and sexual abuse. The concepts of risk and resilience are both discussed. In addition, the chapter looks at the attempt of the government to integrate family-support services and child-protection services: this is discussed in the context of the new government guidance on child-protection procedures and assessment, including the process of dealing with referrals, investigation/assessment, and child-protection conferences. The legal context of child protection is also discussed.

Abused children

Concern about child abuse can be traced back to the latter part of the nineteenth century in most EU countries. Since then, and in line with changing societal attitudes, awareness of child abuse has increased progressively, particularly over recent decades. In the 1960s, child battering was identified as a major cause of child injury and death. The 1970s and 1980s were distinguished by the 'discovery' of widespread sexual abuse of children both inside and outside the family. During the 1990s, increasing attention was paid to the abuse of children within institutions. In the UK, we have seen a number of scandals involving physical and sexual abuse of children and young people by care staff and teachers in residential-care and educational settings (Ruxton, 1996).

Four broad categories of abuse are recognised internationally: physical abuse, emotional abuse, sexual abuse and neglect. It is widely understood that official statistics represent only the tip of a rather large iceberg with respect to the true prevalence of child abuse (Giddens, 1989; Colton and Vanstone, 1996). Even so, the numbers of children placed on child protection registers do provide some idea of levels of violence to children in the UK. On 31 March 1998, there were 31,600 children on child protection

registers in England. This represents 2.8 per 1,000 of all children under 18. The most common reason was neglect, followed by physical abuse, sexual abuse and emotional abuse respectively. This represents a reversal of the previous trend where physical abuse was much more likely to be the reason for registration than neglect. Girls were more likely than boys to be on a register because of sexual abuse – around a third of the girls as compared with a fifth of the boys (Ruxton, 1996).

There is increasing concern about child pornography and the sexual exploitation of children. The possession and dissemination of child pornography is an offence in the UK. A recent study estimated that there had been a 35 per cent rise in the annual number of police cautions administered to young people for soliciting (Lee and O'Brien, 1995). So-called 'sex tourism' is also a significant problem. Substantial numbers of men from the UK, and other technologically advanced countries, visit certain developing countries (e.g., the Philippines, Sri Lanka and Thailand) to buy sex from young child prostitutes. As noted by Sanders (1999), the UK, along with a number of other European countries (Sweden, France and Germany), have passed legislation to make it a criminal offence to travel abroad for the purpose of sexually abusing children. The Sex Offenders Act 1997 (Section 7(1)) prohibits this activity by specifying that:

> any act done by a person in a country or territory outside the United Kingdom which (a) constituted an offence under the law in force in that country or territory; and (b) would constitute a sexual offence to which this section applied if it had been done in England and Wales, or in Northern Ireland, shall constitute that sexual offence under the law of that part of the United Kingdom.

Over recent years, there has been growing professional awareness of other forms of abuse, not least domestic violence. Children are often the hidden victims of this problem. There is a relative lack of research on the impact of domestic violence on children. The first study in Britain showing the devastating effects of domestic violence was published as recently as 1994 (NCH, 1994). Based on information collected from over 100 women, who looked after 246 children, the study found that nearly three-quarters of mothers said that their children had witnessed violent incidents, and 67 per cent had seen their mothers being beaten. Ten per cent of the women had been sexually abused in front of their children. Most of the mothers believed their children were adversely affected in both the short and long term. The problems manifested by the children included: bed-wetting, becoming withdrawn, low self-esteem, violence and aggression towards others, problems at school, and problems in trusting people and forming relationships.

The definition and extent of child maltreatment

The term 'child maltreatment' is more widely used in North America than in the UK but it is useful in that it covers both child abuse and child neglect. In the United States, the Child Abuse Prevention and Treatment Act of 1974 has defined maltreatment as:

> the physical or mental injury, sexual abuse, negligent treatment or maltreatment of a child under the age of 18, by a parent who is responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened.

However, many people would argue that abuse is an act of *commission* while neglect is an act of *omission*: the two are different in kind and ought not to be grouped together. This argument raises the question of whether abuse is in fact different from neglect and how the two ought to be defined. We might say, for example, that while both abuse and neglect result in harm to the child's welfare, the former is deliberate while the latter is not, and so the definitions should revolve around the parent's motivation or intent. Now – at least from the practice standpoint – we are in the position of having to decide whether a parent who, for example, scalded a child's foot in too-hot bath water, intended the scald or just neglected to check the temperature of the water. It is often very difficult to determine motivation, particularly since 'accidents' can contain unconscious intended elements.

A second practical problem in separating abuse from neglect is distinguishing less than optimal care from care that is actually harmful. Can a 12-year-old, for example, be safely left alone for half an hour? Three hours? Overnight? Is it acceptable to discipline a child by slapping with the hand? With a belt? With a cricket bat? Examples of inadequate care fall on a continuum from the slightly neglectful to the grossly abusive. There is also a continuum regarding the actual harm experienced by the child: from subtle forms of emotional damage to physical injury to death. How serious must the harm be before we say it is abusive rather than the result of neglect?

We must also decide whether to include potential as well as actual harm in any definition of neglect. Some people might say that the 12-year-old could be left alone for half an hour but not overnight, on the basis that harm is more likely to occur the longer the child is left. Some might say that a toddler may be allowed to play on the stairs but should not be allowed to play with a knife. The degree of potential harm inherent in these examples is largely a matter of opinion, and it is almost impossible to write a definition of neglect which is neither too broad nor too narrow. A too-broad definition would include the average parent's every lapse of attention, while a too-narrow definition would exclude everyone but the most severely

neglectful. Besharov (1985) has suggested that the deciding criterion ought to be the frequency or length of time (duration) over which the neglectful behaviour continues. A parent whose child comes home to an empty house on one occasion is not neglectful but a parent whose child always returns to an empty house is neglectful. Frequency and duration, again, each lie on a continuum, and there are no agreed-upon answers to the questions 'How often is too often?' and 'How long is too long?' Nevertheless, the idea of persistence (which might include both duration and frequency) has been incorporated into the 'official' definition of child neglect, which also includes the idea of severity (the seriousness of the harm incurred). This definition is derived from the Department of Health et al. (1999, paragraph 2.7, p. 6) guidance on inter-agency working with respect to child abuse, *Working Together*. It runs as follows:

> Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

The official definitions of abuse, derived from the same source (paragraph 2.4, p. 5), divide abuse into three categories, physical, sexual, and emotional. The definitions are:

> Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Munchausen syndrome by proxy.

These definitions include potential (likely) as well as actual harm. Key terms such as 'development' and 'ill-treatment', which are somewhat nebulous, are drawn from the Children Act 1989 and are themselves defined in Section 31 of the Act:

- 'harm' means ill-treatment or the impairment of health or development;
- 'development' means physical, intellectual, emotional, social or behavioural development;
- 'health' means physical or mental health; and
- 'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical.

It may appear that this chapter has paid far too much attention to definitions of abuse and neglect which are ambiguous at best and will anyway have to be interpreted by the social worker with respect to individual cases. However:

> agreed definitions of child abuse are important for two reasons. The first is to establish a general framework within which policies designed to prevent child abuse can be developed and assessed. The second is to provide a set of technical definitions for identifying actions or circumstances which are taken to be abusive. These technical definitions are needed for statutory, legal, statistical, procedural and research purposes. (National Commission of Inquiry into the Prevention of Child Abuse, 1996, p. 1)

In other words, if we are to develop policies to prevent child abuse, we need to know what it is that we are trying to prevent; and if we are to count occurrences of child abuse we need to know what it is that we are counting. For example, one of the decisions for which technical definitions of abuse are needed is the decision about whether a particular child's name should be placed on the child protection register. The process by which a child's name comes to be placed on the register will be discussed later in the chapter. Here, it is sufficient to note that each child protection register lists all the children in the local area who are considered to be at continuing risk of significant harm, and for whom there is a child protection plan (Department of Health et al., 1999, p. 61).

At the end of March 1995, the names of 40,746 children were on child protection registers in the UK. In England, the number registered totaled 34,954 children; around 1 in every 300. Of these, 37 per cent were registered for physical injury, 32 per cent for neglect, 26 per cent for sexual abuse, and 13 per cent for emotional abuse, with 9 per cent registered for more than one category of abuse (National Commission of Inquiry into the Prevention of Child Abuse, 1996).

Unfortunately, the figures on child protection registers do not provide estimates of the true extent of abuse for a number of reasons. For example, not all children on registers have been abused; some are registered because they are thought to be 'at risk'. Registers mainly record abuse within families (intra-familial abuse) and generally exclude extra-familial abuse when the family can protect the child. Many children who are abused may not have their names on the child protection register; registers exclude large numbers of children who do not come to the notice of social workers but who have identical experiences to those registered. Those registered constitute only a minority of those referred to social workers; and, as well as the children referred to social workers, many more are involved in situations where abuse is likely. Children's chances of being registered partly depend on where they live; there is considerable geographical variation in definitions, interpretations and thresholds, reflecting local circumstance, practice and resources. Finally, the widespread practice of recording only one type of abuse reduces the apparent extent of emotional abuse in comparison with other types of abuse (National Commission of Inquiry into the Prevention of Child Abuse, 1996).

It is worth highlighting here that there is good reason to suppose that most cases of child sexual abuse do not come to the notice of child-protection agencies. As Colton and Vanstone (1996, p. 123) state: 'because the tabooed nature of sexual abuse impedes discovery and deters reporting, known cases are very likely to represent only a small proportion of the total number of cases among the general population'. Official figures for England indicate about 4,000 convictions and cautions for sexual offences against children annually. In addition, the names of some 17,000 children are on child protection registers for sexual abuse. However, the report of the National Commission of Inquiry into the Prevention of Child Abuse (1996, p. 14) estimates that as many as 100,000 children each year have a harmful sexual experience and that over a million adults may still be suffering the consequences of sexual abuse.

The report of the National Commission of Inquiry into the Prevention of Child Abuse (1996, p. 4) called for less tolerance of child abuse in general, based on a broader understanding and definition of what constitutes such abuse. The Report observed that 'child protection agencies tend to work to narrow legal and technical definitions of abuse, partly because of fears of widening the net for formal intervention or actions and partly because of the need to allocate scarce resources'.

The Commission argued that 'definitions of abuse should not be governed by the availability of resources. Moreover, if society is to become less tolerant of the abuse of children, there is a need for a wider definition of abuse than is generally accepted'. Thus, the Commission adopted the following broad definition of child abuse:

> Child Abuse consists of anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospects of safe and healthy development into adulthood.
>
> (National Commission of Inquiry into the Prevention of Child Abuse, 1996, p. 2)

This definition covered a 'wide spectrum of damage' from 'actions resulting in criminal convictions' to 'the broader effects of poverty and deprivation'. It is also intended to reflect the principles contained in the United Nations Convention on the Rights of the Child – ratified by the UK government in 1991.

In seeking more realistic estimates of child abuse, the Commission's analysis went far beyond official categories and included a consideration of: poverty and homelessness, children living away from home, children in secure accommodation, school bullying and exclusions, young caregivers, and children and employment.

The Commission also considered racial harassment, from serious violence to name calling. The Commission's report noted:

> For some children there is no escape at school, on the journey to and from school or in the family's immediate neighbourhood. This can seriously constrain social and leisure activities and creates additional pressures on family relationships. (National Commission of Inquiry into the Prevention of Child Abuse, 1996, p. 21)

Currently in the UK, there is no system for recording racial harassment and there is a lack of national research. This is despite the fact that racial harassment is recognised as being widespread, and ethnic record keeping is known to be essential in dealing with institutional racism (Ahmed, 1986, 1994).

The Commission's report further noted that some organisations and their staff were unsuccessful in tackling racial harassment and in tackling the effects of policies which 'unwittingly exclude or disadvantage children from ethnic minorities. This creates distrust of those organisations and individuals and reduces willingness to seek help or support from them' (National Commission of Inquiry into the Prevention of Child Abuse, 1996, p. 21).

On the basis of its broad definition of child abuse, the Commission estimated that at least one million children are harmed each year. At least 150,000 children annually suffer severe physical punishment. Up to 100,000 children each year have a potentially harmful sexual experience. Between 350,000 and 400,000 children live in an environment that is consistently low in warmth and high in criticism. Around 450,000 children are bullied at school at least once a week. Over 4 million children – one in three of all children – in the UK live in poverty (National Commission of Inquiry into the Prevention of Child Abuse, 1996, p. 2).

The Commission's report contended that official statistics not only underestimate abuse but also divert attention from important issues.

> Their focus on an alleged incident or risk, with a single cause, masks the complex social, economic and personal problems which may have contributed to the abuse occurring, and which may not be addressed in child protection procedures. (National Commission of Inquiry into the Prevention of Child Abuse, 1996, p. 12)

In the same vein, the Department of Health emphasises the environment in which incidents of abuse occur:

> any potentially abusive *incident* has to be seen in *context* before the extent of its harm can be assessed and appropriate interventions agreed. An important part of that context is evidence about the ... *outcome* of abuse .... Long term difficulties for children seldom follow from a single abusive event; rather they are more likely to be a consequence of living in an unfavourable environment, particularly one which is low in warmth and high in criticism. (Department of Health, 1995, p. 53)

According to *Child Protection: Messages from Research* (Department of Health, 1995), most cases which come to the notice of child-protection agencies involve children who are in need of support and protection but do not involve serious injury to the child. Whether a child is viewed as being in need of support and protection very much depends on the person doing the viewing. High tolerance on the part of the public and professionals for behaviours that are marginally neglectful or abusive will decrease the numbers of cases reported. The converse will be true if tolerance is low.

For example, while many people believe that any physical punishment of children is wrong (Newell, 1989) and contributes to their emotional maladjustment, others still believe in the right of parents to use physical force to discipline their children. The difficulty for those concerned with reporting child abuse is to differentiate between child abuse and reasonable discipline. Besharov (1990, p. 68) offers the following guidelines for deciding whether a particular physical punishment is 'reasonable':

- Was the purpose of the punishment to preserve discipline or to train or educate the child? Or was the punishment primarily for the parent's gratification or the result of the parent's uncontrolled rage?
- Did the child have the capacity to understand or appreciate the corrective purpose of the discipline? (Very young children and mentally disabled children cannot.)
- Was the punishment appropriate to the child's misbehaviour?
- Was a less severe but equally effective punishment available?
- Was the punishment unnecessarily degrading, brutal or beastly in character or protracted beyond the child's power to endure?
- If physical force was used, was it recklessly applied? (Force directed towards a safe part of the body, such as the buttocks, ordinarily is much more reasonable than is force directed towards vulnerable parts, such as the head or genitals.)

ACTIVITY

Think of a time when either you as a child, or a child known to you, were physically disciplined. Apply the Besharov criteria to it. Was it abusive?

Despite all our efforts to arrive at a generally accepted definition of what is meant by physical abuse, sexual abuse, emotional abuse and neglect, these concepts remain very much open to interpretation by the individual. Yet clear and accepted definitions are essential if professionals and the public are to know what behaviours to report, and child-protection agencies are to know when it is appropriate to intervene with families. A look at the history and a few of the suggested explanations of child abuse may not help us to resolve the dilemma, but it may at least increase our understanding of why a behaviour that is viewed as abusive by one person may be seen as natural and necessary by another. Sanders (1999) has reviewed the historical context of child abuse and child protection in both the UK and the USA and has drawn parallels between the developments in each country.

Understanding the causes of child abuse

There have been numerous attempts to explain child abuse, using different and often conflicting methodological approaches, levels of analysis, and theoretical perspectives. However, none of the theories advanced so far satisfactorily explains the full range of child abuse. At best, they offer only partial accounts. Thus, whilst they contradict one another in important ways, the different perspectives are perhaps most fruitfully seen as complementary approaches. In what follows, we outline a number of influential perspectives that have sought to explain child abuse, beginning with attachment theory. The names should be familiar from our discussion of child-developmental theorists in Chapter 2.

Attachment theory

Kempe, the American paediatrician credited with rediscovering child abuse (Kempe and Helfer, 1968; Kempe and Kempe, 1978), focused on the importance of the attachment between mother and child in explaining physical abuse. Kempe's approach was informed by the work of Bowlby (see 1953; 1969; 1973; 1985; 1988) on attachment and maternal deprivation. Kempe observed that mothers who abuse their children have themselves often suffered from poor attachment experiences and are thus

unable to serve as good attachment figures for their own children. They expect their children to be naturally rewarding and, when this unrealistic expectation is not fulfilled, they frequently turn to physical abuse. In light of this, once steps had been taken to protect the child concerned, Kempe considered that treatment should focus on the parents through the provision of the supportive 'mothering' relationship that the parents themselves had missed as children. With respect to prevention, evidence of lack of bonding between mother and infant in the perinatal period could be taken as an indicator that the child was at risk of abuse.

A social-learning approach

Social learning theory, which has its origins in behaviourism, views child abuse as a consequence of poor learning experiences and inadequate controlling techniques. Parents who were themselves maltreated as children may not have learned how to control their children effectively using socially approved methods; instead, they adopt an abusive approach. Equally, parents who were overindulged as children are unable to establish appropriate limits and turn to violence when their own children go too far. Learning theorists have developed a range of behaviour-modification techniques. In the area of child abuse, attention has concentrated on supplanting inappropriate and ineffective approaches to parenting with those that are both effective and socially acceptable (McCauley, 1977).

Behavioural modification techniques have also been used with actual or potential offenders for some years now. The social-learning perspective views sexually abusive behaviour, for example, as behaviour that has been learned (Bandura, 1965). Abusers associate certain kinds of stimuli, such as sexual images of children, with sexual gratification, possibly as a result of sexual experiences during their own childhoods. This sexual orientation is reinforced through masturbation to fantasies of child abuse and reinforced by belief systems which provide a rationalisation for abusive behaviour. These belief systems challenge the sexual ethics and moral standards of the wider society, and include ideas such as: children can consent to and enjoy sex with adults; and, sex between children and adults is natural, healthy and positive. These views are reinforced through contact with other abusers who have similar beliefs, and may be used by abusers not only to justify their behaviour but also to minimise any guilt they might experience (Sampson, 1994).

This perspective on how sexually abusive behaviour develops helps to explain why some adults are sexually attracted to children, and suggests that abusive behaviour can be changed; that what has been learned can be unlearned.

Family dysfunction theory

A more recent perspective that has been applied to both physical and sexual abuse is family dysfunction theory and its associated method of therapeutic intervention, family therapy. In the 1960s, the majority of family therapists operated from a psychodynamic perspective and adopted a fairly passive role. However, a more directive approach has been advocated by Minuchin (1974), who employs systems theory as an aid to understanding and intervening with families.

Minuchin sees the family as comprised of parent–parent, parent–child and child–child subsystems. In his view, it is important to maintain clear distinctions between these subsystems. He argues that families can become 'enmeshed': a state where the roles and behaviours expected of 'mother', 'father' and 'child' are blurred and a child might assume a parental role, or vice versa. Alternatively, family members can become 'disengaged' from each other and interact barely at all, either within or between subsystems. Enmeshment and disengagement lie at extreme ends of a continuum of family interaction. For Minuchin, both extremes are dysfunctional, and the therapist's task is to achieve a healthy balance between too much and too little family interaction. Interaction between the family and wider systems such as schools is also important and constitutes another continuum. A healthy family maintains boundaries around itself but also encourages its members to participate in activities outside the family. Closed families, where the family boundaries are rigid and there is minimal interaction with the outside world, lie at one end of the family–other system continuum and also tend towards enmeshment. At the other end of the continuum, the family boundaries may be so permeable that members are not sure who does and does not belong to the family, or even, since members often move in and out, who is supposed to be living in the house. This may occur, for example, when a parent frequently changes partners, or step-siblings move between parents and live in different houses for varying periods of time. Not surprisingly, these families tend towards disengagement.

The concept of 'scapegoating' is also important in family systems theory. Scapegoating refers to the process by which one family member, often a child, is blamed for all the family's problems and is physically or emotionally abused as punishment. Laying blame in this way allows family members to avoid looking at other reasons for their problems and enables them to survive as a unit. Since the scapegoated child is essential to family preservation, any attempt to make the family safe for the child requires that the therapist work with the whole family to identify and attempt to resolve family problems (Corby, 1989).

Families where sexual abuse occurs are usually enmeshed and isolated from the outside world. For example, where the sexual relationship between the parents is unsatisfactory and the boundaries between parents and children are blurred, the father may turn his attention to an adolescent daughter, who takes over the mother's role not only sexually but often also with respect to household chores. The therapist's task is to work with the whole family in an effort to disentangle poor communication patterns and relationships (Mrazek and Bentovim, 1981).

The feminist perspective

The feminist writer Dominelli takes a rather different view of why sexual abuse occurs from that advanced by family-dysfunction theorists. She states:

> abuse in the form of violence against women is a normal feature of patriarchal relations. It is a major vehicle men use in controlling women. The rising incidence of child sexual abuse reveals the extent to which men are prepared to wield sexual violence as a major weapon in asserting their authority over women. (Dominelli, 1986, p. 12)

From this perspective, sexual abuse represents an extreme manifestation of institutionalised male power over females, rather than family communication problems or individual pathology. Feminists argue that men sexually abuse children because of the power imbalance between the genders and the consequent differing patterns of socialisation experienced by males and females. The obvious policy implication of this is that sexual abuse has to be tackled at the societal as well as the individual level (Rush, 1980; Dominelli, 1986; Driver and Droisen, 1989).

The feminist philosophy has made an invaluable contribution to our understanding of why sexual abuse occurs. Analysing and challenging male–female power relations at an institutional level has provided very important insights for child-protection work. However, there is a danger that feminist theory can be used in a reductionist and exclusive way, whereby every social problem is attributed to patriarchy. Moreover, the diversity of human sexual desire, and the fact that some men are sexually aroused primarily by children or by other men, appear to pose a challenge to feminist theory. So too do the (comparatively rare) examples of sexual offending by women (except where women have been coerced into such behaviour by men), and those instances where females use positions of power in an abusive way (Colton and Vanstone, 1996). It might also be noted that, whereas females are more likely to suffer sexual-abuse than males, the discrepancy is less than was once thought. Finkelhor (1993) estimates

that about 29 per cent of sexual abuse victims in the United States are male, though boys are less likely to be reported to child-protective services than girls.

Sociological viewpoints

Sociological perspectives were developed by theorists in the United States during the 1970s and 1980s. Corby (1989) distinguishes three main strands of such thought: ecological, social cultural, and social structural.

Ecological theories emphasise that the healthy development of children requires healthy living environments. Socially impoverished environments exacerbate, and even engender, psychological stress in disadvantaged families. Child abuse is seen as a consequence of poor parenting skills and social stress caused by lack of family and social supports. Thus, it is suggested that families at risk should not be grouped together into a single neighbourhood, and that services must be adequately resourced and sensitive to the needs of local communities (Garbarino and Gilliam, 1980).

Social cultural theory holds that the incidence of child abuse is related to cultural support for the physical punishment of children, and cultural discomfort with the idea of challenging the rights of parents and intruding upon the privacy of the home. Moreover, violence against children is much more widespread than official estimates of child physical abuse appear to indicate. The solution requires a wider societal approach to dealing with violence as a whole. Currently, although the official attitude towards child abuse is disapproval, violence towards children is, in fact, passively condoned by a lack of a determined attempt to eradicate it (Gelles and Cornell, 1985).

The social structural perspective is underpinned by research undertaken by Gil (1978) which shows that children on child protection registers in the United States in the late 1960s mainly came from the lower social classes. According to this perspective, society establishes the preconditions for child abuse by condoning structural inequalities; that is to say, by allowing many families to live in acute poverty and social deprivation. Therefore, society must share the blame for child abuse, which should not be regarded as the result of individual failure. Child abuse is a political concern, and cannot be tackled by social workers alone. Rather than trying to change the behaviour of individuals and families by psychologically-oriented intervention, attention should focus on ameliorating the inequalities that result in impoverishment and poor living conditions (Gil, 1978).

Although sociological perspectives on child abuse were originally promulgated in the United States, many have expressed similar views in Britain (see, for example, Parton, 1985; Holman, 1988). Moreover, the

report of the Rowntree Inquiry into Income and Wealth (Hills, 1995) documented a pattern of 'poor parenting' in the most disadvantaged council estates in Britain. However, it was argued that this did not result from poverty alone but from high rates of family break-up, lack of understanding of children's needs, social isolation and universally high rates of unemployment among young people – many of whom were already parents themselves. Around five times the number of children were on the 'at risk' registers from the poorest estates as from other areas of the same city. Similar findings have been reported by other studies (Waterhouse, 1997).

An integrated perspective on sexual abuse

With respect to child maltreatment in general, controversy has raged for years over whether the basic cause lies in the psychopathology of parents or in social, economic and cultural factors. We might remember that child maltreatment is a very complex phenomenon and is likely to be diverse in causation: in short, all of the opposing schools are likely to be right in some respect at least part of the time. With respect to physical abuse, Belsky and Vondra (1989) put forward an integrated model that emphasises the following determinants of parenting: developmental history, personality, work, marital relations, parenting experienced by the parents when they were children, social networks, the child's characteristics, and the child's development.

With respect to sexual abuse in particular, recent years have seen the development of approaches which seek to combine elements from different schools to provide a more powerful explanatory theory of child sexual abuse (Finkelhor, 1984; Marshall and Barbaree, 1990). These theories directly inform most of the work undertaken with sex offenders in Britain and suggest that a range of psychological and socio-structural factors contribute to child sexual abuse (Colton and Vanstone, 1996).

For example, Finkelhor (1984) suggests a four-stage process through which offenders pass when committing acts of abuse. First, the offender must be motivated to abuse a child. There are three components to the source of this motivation:

(i) emotional congruence – relating sexually to the child satisfies some important sexual need;
(ii) sexual arousal – the child comes to be the potential source of sexual gratification;
(iii) alternative sources of sexual gratification are not available, or are less satisfying.

Secondly, the offender must overcome his internal inhibitions against acting on his motivation. Abusers' own moral scruples can be overcome

through alcohol or drugs, or may be undermined by psychosis, impulse disorder, senility, stress, or a failure of the incest-inhibition mechanism in family dynamics. Internal inhibitors may also be undermined by wider social factors such as apparent toleration of sexual interest in children, weak criminal sanctions against offenders, the ideology of the patriarchal prerogatives of fathers, and social toleration of deviant acts committed while intoxicated.

Thirdly, the offender must overcome external impediments to committing abuse. He must gain access to a victim and also have the opportunity to abuse. Both conditions can be easily met in the case of incest or intra-familial abuse. However, opportunities for non-familial (or extra-familial) abuse must be more actively sought. Thus, many abusers consciously plan opportunities to gain access to children. They seek out places where children are gathered, and cultivate acquaintance with those who have children. Many of those convicted of child sexual abuse committed their offences while employed as teachers, social workers, youth leaders and members of the clergy. Some such individuals deliberately seek positions with children so that they can engage in sexual abuse.

Finally, the child's resistance to sexual abuse must be overcome. Many abusers are in positions of power or trust in relation to their victims, which makes it easier to overcome such resistance. Abusers may use threats, coercion, violence, bribery, or reward to gain the compliance of their victims. Resistance will also be easier to overcome where the child is isolated or deprived, ignorant of sexual matters, and lacking the requisite knowledge or confidence to resist. Many abusers report 'grooming' their victims and may be very adept at obtaining compliance and ensuring that the child stays silent later on (Colton and Vanstone, 1996).

Colton and Vanstone (1996, p. 21) report that the strengths of Finkelhor's four-preconditions model include the following:

1. It combines psychological and sociological explanations of child sexual abuse.
2. It is at a sufficiently general level to integrate all forms of intra- and extra-familial abuse.
3. It suggests that abuse by both fathers and paedophiles require an explanation of how the sexual interest in the child arose, why there were no effective inhibitors, and why the child's resistance was either absent or insufficient.
4. It applies both to offenders whose deviant behaviour results from deviant sexual preference for children ('fixated' offenders) and to those whose behaviour is situationally induced and occurs in the context of a normal sexual preference structure ('regressed' offenders).

5. It puts responsibility for abuse in perspective and, unlike some explanations, does not remove responsibility from the offender and displace it onto victims, third parties or society as a whole.
6. It has direct implications for working with abusive families and individuals because it shows that evaluation and intervention can operate at four separate sites to prevent sexual abuse from re-occurring.

In conclusion, it is clear that child abuse is a product of an interplay between multiple factors: psychological, cultural and social. The influence of this viewpoint is evidenced in the broad definition of child abuse adopted by the report of the National Commission of Inquiry into the Prevention of Child Abuse (1996).

The consequences of child abuse

Physical abuse and neglect

The physical abuse of children and young people spans a range of actions from what some would see as 'justifiable chastisement' (for example, slapping or caning), to what most would agree constitute premeditated acts of sadistic cruelty against children. The immediate effects of physical abuse reflect the nature and severity of the injuries inflicted. They range from minor bruising and abrasions to fractured bones. In exceptional cases, severe internal injuries such as damage to the spleen, liver and kidney, which may result from punching and kicking, can prove fatal if left untreated.

The commoner non-accidental injuries in babies and young children include fractured ribs caused by excessive squeezing, and twisting fractures of the long bones of the arms and legs. In a young child, a bone may crack and distort, rather than break, resulting in a greenstick fracture. Fortunately, most such injuries heal over time without leaving permanent damage. But this is not the case in relation to the effect of subdural haematoma (bleeding into the membranes surrounding the brain) and retinal haemorrhage (bleeding in the back of the eye). Both can be caused by blows to the head or can be associated with a fractured skull; they can also result from violent shaking, which leaves minimal superficial evidence – for example, grip marks on the chest or upper arms. Retinal haemorrhage may result in blindness, and the unrelieved pressure on the brain from a subdural haematoma can cause permanent brain damage and mental retardation (Kenward and Hevey, 1989).

Besharov (1990, pp. 70–1) has identified a number of factors which might lead to the suspicion that an injury was caused by abuse. These

factors include the following:

- *The child's level of development.* Given the limited capacity of infants to move about and injure themselves, any injury to an infant is considered suspicious.
- *The shape of the injury.* The child's body may show the shape of the object used to inflict the injury: for example, a belt buckle or a hot iron.
- *The location of the injury.* Children falling by accident tend to injure their chins, foreheads, hands, elbows, knees and shins. Injuries to other areas – thighs, upper arms, genital and rectal areas, buttocks and the back of the legs or torso – are rarely caused by anything other than a physical assault.
- *The type of injury.* It is almost impossible for some injuries to be self-inflicted. Some types of fractures, for example, can only be caused by pulling, jerking or twisting the long bones in the arms or legs.
- *The number of old and new injuries.* Although physical abuse can be an isolated event, it more usually consists of a pattern of repeated assaults. Multiple injuries in various stages of healing are not signs of an accident-prone child but of physical abuse.

Research indicates that children who suffer abuse, including those who experience emotional deprivation, show delays in their physical growth and mental development. It is also well established that social disadvantage *per se* can seriously damage the life chances of children. Sadly, for many socially disadvantaged children, neglect or active abuse by their parents is just one more factor in a generally abusive environment (Kenward and Hevey, 1989). However, it is also clear that good care and educational opportunities can compensate for bad experience irrespective of the child's age.

The behavioural characteristics of physically abused and neglected children include: an impaired capacity to enjoy life (often sad, preoccupied or listless); psychiatric or psychosomatic stress symptoms (such as bedwetting, bizarre behaviour, and eating problems); low self-esteem and feelings of worthlessness; learning problems at school (for example, lack of concentration); withdrawal; opposition defiance; hypervigilance (an expression of 'frozen watchfulness'); compulsivity and pseudo-mature behaviour (a false appearance of independence or of always being excessively 'good' or offering indiscriminate affection to all adults who show an interest) (Kenward and Hevey, 1989).

None of the behaviours listed above are exclusive to abused children; nor are they manifested by all those who suffer abuse. How children react depends on a complex interplay between a number of factors: the child's personality, particular family circumstances and relationships, and the nature, severity and duration of the abuse inflicted. Whilst it appears that

adults who were abused in childhood are at higher risk of abusing their own children, by no means all abused children develop into abusive adults. As Kenward and Hevey (1989) state:

> Children have proved remarkably resilient to all forms of maltreatment and many thousands who have experienced what would be considered abusive childhoods by contemporary standards have become affectionate, caring and sensitive parents.

In recent years, there has been increased interest in resilient children who transcend abusive childhoods to become successful adults. It seems likely that both personal and environmental factors contribute to resiliency. Personal qualities of resilient children are thought to include good intellectual ability, a positive attitude towards others, physical attractiveness, enthusiasm, and an internal locus of control. External factors are the presence of caring adults outside the abusive family who take a strong interest in the child, and parents who, despite being abusive, are able to offer some family stability, an expectation of academic performance, and a home atmosphere in which the abuse is sporadic rather than a constant, pervasive element.

Sexual abuse

Sexual abuse has been defined as 'any act occurring between people who are at different developmental stages which is for the sexual gratification of the person at the more advanced developmental stage' (Coulborn Faller, 1988, p. 11). This definition includes sexual acts between children, provided that the perpetrator and the victim are at different developmental stages. For example, an adolescent may abuse a younger child, or one child may abuse another of the same age who is mentally disadvantaged.

Risk factors

Before looking at the consequences of child sexual abuse, it is worth considering who is abused, or so-called 'risk factors'. It is clear that girls are more likely to be sexually victimised than boys although, as previously mentioned, the discrepancy is less than was once thought. Research by Russell (1984) suggests that over half of all women are subject to some form of sexual abuse prior to reaching the age of 18. Although by no means all such cases would require intervention from child-protection agencies, Russell also found that around 16 per cent of women experience some form of incestuous abuse, two-thirds of which can be regarded as serious or very serious. Russell's work indicates that official incidence rates represent the tip of the iceberg of child sexual abuse cases (Colton and Vanstone, 1996).

Finkelhor (1986) and his associates discovered that the most common age at which both boys and girls begin to experience abuse is between 8 and 12 years of age. However, we should not overlook the fact that much younger children may be subjected to child sexual abuse (Colton and Vanstone, 1996).

Finkelhor (1984) has also explored the question of why some children experience abuse while others do not. He reports that eight of the strongest independent predictors of sexual victimisation among girls and young women are:

- *Having a stepfather.* Most stepfathers do not abuse their stepchildren. However, having a stepfather in the home does somewhat increase the risk of sexual abuse for girls, particularly if the stepfather offers an affection which the child did not receive from her natural father.
- *Living in a single-parent family.* Children from single-parent families or children whose mothers are disabled or out of the home for extensive periods are at somewhat higher risk than other children.
- *Having a poor relationship with the mother.* Children who are not close to their mothers tend to be more vulnerable to sexual abuse and are also more likely to 'keep it secret' when initial sexual advances are made.
- *Mother did not finish high school.* Higher risk of abuse has been found to correlate with low educational achievement by parents, particularly by mothers because they tend to have more contact with children.
- *Certain parental characteristics.* Parental characteristics associated with increased risk for children include poor supervision of children, punitive discipline, extreme marital conflict, parental violence, substance abuse, and depression.
- *A punitive attitude with respect to sexual matters on the part of the mother.* Children are less likely to confide in mothers who are blaming and punitive with respect to sexual matters.
- *Household with low income.* As ecological theory tells us, an impoverished environment increases the risk of all forms of abuse. However, it should be emphasised that abuse occurs at every socio-economic level.
- *Having only two friends or less in childhood.* Isolated children tend to be more susceptible to the ploys of child molesters who offer attention and affection.

Obviously, the risk factors listed above are too general to be of use in identifying specific cases of sexual abuse. They are perhaps more useful in enabling social workers to select groups of children for prevention programmes.

Consequences of sexual abuse

The harrowing accounts of women who were sexually victimised during childhood (e.g., Rush, 1980; Spring, 1987) have not only increased awareness and sensitivity about the adverse consequences of sexual abuse but have also fuelled a growing body of research into the short- and long-term effects of abuse. The short-term effects include a range of emotional and behavioural problems, including: general psychopathology, fearfulness, depression, withdrawal and suicide, hostility and aggression, low self-esteem, guilt and shame. Other short-term effects include physical symptoms, running away and other 'acting out' disorders, cognitive disability, developmental delay and poor school performance, as well as inappropriate sexual behaviour (Colton and Vanstone, 1996).

However, Corby (1993) argues that the only clear and direct initial outcome of sexual abuse appears to be the inappropriately sexualised behaviour that occurs in up to a third of all sexually victimised children. He also maintains that sexual abuse, in itself, does not appear to have an incapacitating effect in the short term for most children.

Corby (1993) states that the links between sexual abuse and emotional and behavioural difficulties are even more problematic in relation to long-term effects. This is partly because of the much greater length of time between the abuse and the observed behaviour problems, and also because of the possible effects of a much larger number of intervening variables. Even so, research does indicate that women who have been sexually abused as children are more likely than other women to encounter difficulties in relation to fear, anxiety, self-esteem, depression, and sexual satisfaction; they are also more vulnerable to further abuse. It may be concluded, therefore, that child sexual abuse can have a serious adverse effect on long-term mental health (Colton and Vanstone, 1996).

Research indicates that sexual abuse is likely to be most harmful in cases where the abusive act involved penetration, the abuse has persisted for some time, the abuser is a father figure, the abuse is accompanied by violence, force and/or the threat of it, and the response of the child's family to disclosure is negative (for example, the child is not believed or is blamed for the abuse).

The age and sex of victims may also have an impact on the outcome, but the nature of these relationships is not clear. Neither is it always clear whether intervention by child protection agencies has a positive or negative effect on the outcome for victims (Colton and Vanstone, 1996). Intervention possibilities may include removing the perpetrator from the home, removing the child if the mother is unable or unwilling to prevent continued access to the child by the perpetrator, and criminal prosecution of the perpetrator. All of these possibilities involve emotional trauma to the family

and possibly financial deprivation as well if the perpetrator was also the breadwinner. Even if the child is not blamed for the situation, the family will have mixed feelings about criminally prosecuting a father or father figure. In addition, the child may be further traumatised by having to describe the circumstances of the abuse many times to many different investigators. If the case is criminally prosecuted, the child faces public court appearances, sometimes delayed for as long as two years after the initial disclosure was made. Duquette (1988, pp. 399–403) has identified several procedures which may serve to reduce trauma to the child during the investigative phase:

- Reduce the number of interviews and interviewers the child must endure by coordinating the procedures of different agencies: for example, child protection, the police, and the juvenile and criminal courts.
- Employ 'vertical prosecution' in which a single prosecutor is assigned to the case through all stages of the proceedings.
- Videotape the initial interview so that those who need to know the child's story can watch the videotape. Videotapes may be able to substitute for the child's testimony in some courts.
- Allow an emotionally supportive adult, such as a relative or victim-advocate, to accompany the child through all stages of the legal process. It will also be helpful if the child, and the mother if she is supportive, have been prepared for what will happen in court through participation in a victim-witness programme.
- Allow children with limited vocabularies to use anatomically correct dolls and drawings with which they can demonstrate what happened to them.
- Expedite the legal process.

Despite our best efforts, child-welfare intervention is bound to be traumatic, but the alternative to intervention is that the abuse will continue and therapeutic services will not be offered. Treatment programmes for sexual-abuse victims and their non-offending parents (usually the mother) vary widely with respect to both philosophy and structure. As previously mentioned, the feminist perspective views sexual abuse as a demonstration of institutionalised male power over women: programmes offered from this perspective often work towards permanent exclusion of the perpetrator from the family unit and focus on promoting healing and independence in the victim, her mother and siblings. Conversely, systems theorists may work towards reunification of the perpetrator with the family, provided that this does not compromise the future safety of the child. Some programmes offer only group therapy for 2–3 hours a week over 10–14 weeks, while others offer a progression of individual, couple, group and family therapy for periods up to two years or even longer.

The child-protection system

No aspect of the social-work task is more challenging or has aroused more concern than child protection. In the UK, the tragic death of Maria Colwell in 1973, and the public inquiry that followed, marked the beginning of the contemporary political, public and professional interest in the issue of child abuse (Parton, 1985; Parton and Parton, 1989). Following the recommendations of the inquiry (DHSS, 1974, 1982), a nationally coordinated child-protection system has evolved (Waterhouse, 1997). This system requires the effective coordination of child-protection agencies, and it also involves communication and cooperation between a number of professionals from other agencies (Hallett and Stevenson, 1980; Home Office et al., 1991; Hallett and Birchall, 1992; Hallett, 1995; Birchall and Hallett, 1995; Colton et al., 1996; Sanders et al., 1997; Sanders and Thomas, 1997; Sanders, 1999).

Those particularly involved in the process of gathering relevant information and working with the child and family include: social workers, health visitors, general practitioners, paediatricians, police officers, and representatives of the NSPCC (National Society for the Prevention of Cruelty to Children). Probation officers, teachers and psychiatrists may also make an important contribution. In addition, expert advice may be needed in a number of areas, including issues associated with race, culture, and disability. Such advice may be obtained from professionals like medical specialists, psychologists and lawyers and from members of ethnic communities, particularly those skilled in the translation of languages and cultural value systems.

Work on individual child-protection cases follows the basic principles of the Children Act 1989. These principles include a focus on the welfare of the child (taking into account the child's views in the light of his or her age and understanding), partnership with parents and other family members, the concept of parental responsibility, sensitivity to issues of gender, race, culture and disability, and a shared mutual understanding of the goals of child-protection work and of what constitutes good practice.

It is essential that all stages of the child-protection process are recorded. All agencies must have clear policies to ensure good record keeping, which should include giving children and parents access to records. Records must be accurate and clear; they should include all the information that is known to the agency about the child and family; and should reflect all the work

undertaken with the agency and working arrangements with staff in other agencies (Home Office et al., 1991).

In the last five years there has been a radical rethinking about the role of child protection in promoting the welfare of children who are vulnerable to abuse, and this has been reflected in the way the government has responded to the themes from *Child Protection: Messages from Research* (Department of Health, 1995) by revising *Working Together under the Children Act 1989* (Home Office et al., 1991) to produce *Working Together to Safeguard Children* (Department of Health et al., 1999). The reason for the production of the revised guidance was to develop a child-protection service that was more integrated with services for children in need: in other words, to integrate protection with prevention. The main means to achieve this was the production of a unified framework for assessment (Department of Health et al., 2000), which is to be used both for children in need and for abused and neglected children.

Under the original guidance (Home Office et al., 1991), the stages of work with individual cases were described as referral and recognition; immediate protection and planning the investigation; investigation and initial assessment; child-protection conference and decision-making about the need for registration; comprehensive assessment and planning; and implementation, review and, where appropriate, de-registration. Under the new guidance, all referrals concerning the welfare of a child will begin by being processed in the same way, but will have differential outcomes (and different exit points from the process) depending upon how the information and assessments unfold.

The new guidance indicates that everybody who works with children should be aware of indicators that a child's welfare may be at risk. They should be mindful of this whether they are working directly with children, with parents or caregivers (who may need help in promoting and safeguarding the welfare of their children), or with family members, employees, or others who have contact with children. Professionals from specific disciplines should have particular arrangements for ensuring that those who have less contact with the child-protection system are still sufficiently knowledgeable to know what kinds of issues should raise concerns, and to whom those concerns should be passed when they arise.

All schools and colleges should have a designated member of staff with special knowledge and skills in recognising abuse. The designated person will also have knowledge of the local child-protection procedures and know what to do when concerns about a particular child or young person arise. Likewise, health services should have their own arrangements. Health authorities will have a senior paediatrician and a senior nurse (with health visiting qualification) to act as 'designated senior professional'. This 'senior professional' will

not necessarily become professionally involved in every locally referred child-protection case, but will certainly have a role as coordinator of information about child protection, and may well be involved in training and professional development concerning child abuse and child protection. The NHS Trusts as well should have specific professionals (doctor, nurse, midwife) with responsibility for child protection, referred to as 'named' professionals.

The process of handling individual cases is summarised in Table 5.1. Referrals to social services should normally have a decision made within 24 hours. That decision can be that no further action is necessary, or that services should be provided by another agency, or that further action (e.g., initial assessment) is needed. Under normal circumstances, agencies referring a family to social services should discuss the referral with the family first (unless seeking the family's agreement would place the child at increased risk). Members of the public making referrals should be able to be assured that personal information about them will not be disclosed to anyone without their consent. Referrers (both agency and members of the public) should have information about what has happened in respect of the referral made, but where the information is given to members of the public it must be done in a manner respecting the confidentiality of the child and family.

Table 5.1 *Referrals to social services departments where there are child-welfare concerns*

Referral (to be decided within 24 hours)	**Initial assessment** (not later than 7 working days)	**Core assessment** (not later than 35 working days)
• no further action	• involves seeing and speaking to the child, and family	• if child is in need, a core assessment
• provision of services or other help (from own or other agencies)	• obtaining information from sources and other professionals	• if significant harm, make inquiries under Section 47
• an initial assessment is required	• is this a child in need? (Section 17)	
	• is there reasonable cause to suspect that this child is suffering, or is likely to suffer, significant harm? (Section 47)	
	• decisions should be endorsed at managerial level and recorded	

If it is decided that further assessment is necessary, then the new *Framework for the Assessment of Children in Need and their Families* (Department of Health et al., 2000) comes into play. The broad outline of the frame-work is three major headings with six or seven subheadings under each heading:

1. **Dimensions of the child's developmental needs**
   Health
   Education
   Emotional and behavioural development
   Identity
   Family and social relationships
   Social presentation
   Self-care skills

2. **Dimensions of parenting capacity**
   Basic care
   Ensuring safety
   Emotional warmth
   Stimulation
   Guidance and boundaries
   Stability

3. **Family and environmental factors**
   Family history and functioning
   Wider family
   Housing
   Employment
   Income
   Family's social integration
   Community resources

Using the three dimensions (and the subheadings) the initial assessment should address the following three questions (Department of Health et al., 2000, p. 41):

- What are the needs of the child?
- Are the parents able to respond appropriately to the child's needs? Is the child being adequately safeguarded from significant harm, and are the parents able to promote the child's health and development?
- Is action required to safeguard and promote the child's welfare?

This assessment should involve direct contact with the child and the family, the compilation of all available information about the child and the family, and information from other professionals. It is during this initial assessment that a decision may be made about whether the situation concerns a child

in need (Section 17) requiring a family-support response, or whether it is a situation involving actual or potential significant harm requiring a child-protection response (Section 47 – see below).

The guidance draws on research (Cleaver et al., 1998) to emphasise pitfalls that may occur during an initial assessment. These include: not giving enough weight to information from family, friends and neighbours; not giving enough attention to what children say, and how they look and behave; focusing attention too narrowly on the most pressing or visible problem; over-precipitate action (based on media or senior management concerns); failing to check out the understanding of family members; basing conclusions on assumptions and pre-judgements; misinterpreting parental behaviour; failing to redirect families to other services (when the risk of significant harm is not established); reluctance of workers to assess the risk to personal safety (or to ask for help when concerned); and lack of recording. With so many potential pitfalls, it is indeed a wonder that an adequate initial assessment is ever achieved.

Where there is no concern about actual or potential significant harm, there may still be 'child in need' concerns, and the initial assessment should proceed to a core assessment as a basis for the provision of family-support services. Interestingly, the guidance discusses the role of Family Group Conferences (normally applied in contexts of child protection and/or youth offending) as a means of taking forward the work with families of children in need.

Where there is a concern about actual or likely significant harm, then a 'Section 47 inquiry' must be undertaken. Section 47 of the Act states:

> Where a local authority (a) are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order; or (ii) is in police protection; or (b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

Where there is risk of immediate harm to the child, then an agency with statutory powers (for example, police, NSPCC, social services) should act without delay to ensure the child's immediate safety. Even under such circumstances there should be a preliminary 'strategy discussion' between the relevant agencies, but the guidance anticipates that sometimes even this may not be possible, in which case such a discussion should take place as soon as possible afterwards. There is a range of methods for securing a child's immediate safety. In recent years protection agencies have had legal options requiring the removal of the perpetrator (under the Family

Law Act 1996) rather than removing the child. Other options can include orders to keep a child where he or she is, thus preventing removal from a safe environment. Some of these options are discussed below in 'The legal framework'.

The 'strategy discussion' (which may or may not be a meeting) should involve social services, police, a senior doctor (where a medical examination may be needed), and other relevant agencies (and in particular the agency making the referral). The purpose of the strategy discussion is primarily to plan how the inquiries should be handled (once it is established that an inquiry should be begun, or continued). The agencies will develop an immediate action plan to protect the child, and will decide on what information arising from the strategy discussion should be shared with the family. Information that is shared, and decisions that are reached about action to be taken, should be recorded.

Where a core assessment is required as part of Section 47 inquiries, the framework again provides the structure for pulling together all of the necessary information to enable decision-making. However, the timing of the subsequent child-protection action (child protection conference) means that the full core assessment will not be completed by the time of the conference. It is at this very early stage that the child and family should be prepared for participation in the inquiry process. Obstacles to their full participation (young age of child, communication difficulties, ethnicity) should be addressed. The parents would normally be involved and their consent requested for an inquiry in relation to the child. There may, however, be some circumstances when such consent may not be sought, and indeed some circumstances where the parent would not be informed about the inquiry, because to do so would place the child at greater risk.

Videotaped interviews may be conducted as part of the inquiry process. There is now a legal presumption that children under the age of 17 years will give evidence through pre-recorded videotaped interviews (Youth and Criminal Justice Act 1999).

Families should be provided with a written record of the outcome of a Section 47 inquiry. There are basically three possible outcomes: the concerns are not substantiated; the concerns are substantiated, but the child is not considered to be at *continuing* risk of significant harm; or the concerns are substantiated and the child is considered to be at continued risk of significant harm.

In the first case, it is important that the family be offered the opportunity of family-support services if the child is considered to be a child in need. It may be that the concerns about the risk of significant harm were not completely allayed by the inquiry, but there is insufficient evidence upon which to base any other decision. In such a case, agencies may want to monitor the

situation, but the guidance is quite clear that such monitoring should not be used as a means of avoiding or delaying making a difficult decision.

In the second case, where there clearly was a risk of significant harm to the child, but that risk is not seen as continuing, it is possible for the agencies to decide not to convene a child-protection conference (because an inter-agency plan is not seen as necessary). It is specifically in this provision that we can see the attempt of the government, with caution, to introduce the 'lighter touch' in child protection that seemed to be such a clear message from the research summarised in 1995 (Department of Health, 1995). It is perhaps specifically this type of situation, in which harm had been established, where agencies previously may have felt obliged to put the child's name on the register.

However, the examples provided by the government in the present guidance (the abuser has left home, isolated instance of abuse by a stranger), when combined with the cautionary notes about the 'dangers of misplaced professional optimism' (p. 51), do not encourage agencies to dispense with a child-protection conference. The guidance also requires that a decision not to hold a conference be endorsed by 'a suitably qualified and designated person within the social services department' (p. 51). Research into the percentage of cases in which a conference is held and under what circumstances could be very illuminating.

Child-protection conference

In the third case, where the risk of significant harm continues, there should be a child-protection conference. The purpose of the initial child-protection conference (which should be held within 15 working days of the strategy meeting) is to bring together the information about the child's health, development and functioning and the parent's (or carer's) capacity, assess the likelihood of future significant harm, and decide on what action is needed, how that action will be undertaken, and what the objectives of that action are. Initial child-protection conferences are generally quite large, and include professionals who have a contribution to make by virtue of either their expertise or their knowledge of the family (or both). The person chairing the conference will be someone who does not have operational line management for the case. A quorum for attendance is the social services department plus at least two other agencies, although in exceptional circumstances a conference may proceed without this quorum.

Over the last ten years there has been a gradual transition from parental attendance being the exception to parental attendance being the norm – though the transition has not been without difficulties (Cleaver and Freeman, 1995; Thoburn et al., 1995). More recently, attention has been

given to the involvement of young people in the child-protection process. The young person may appear himself or an advocate may appear on his behalf. However, as noted in the guidance: 'Adults and any children who wish to make representations to the conference may not wish to speak in front of one another' (Department of Health et al., 1999, p. 53). Therefore, it may be necessary to do a bit of shuffling during conferences to allow the direct but separate input of both the parents and the child. It is important that parents and children are prepared for attendance at the conference, and are helped to formulate the main points that they would like to convey. There are times when parents will be excluded from attending part or even all of a conference. The main criterion for this is when the presence of the parent (perhaps because of the threat of violence or intimidation) would interfere with the process. The guidance points out, however, that the fact that a parent is being prosecuted is not in itself a reason for exclusion, although there may need to be some discussions with the police and the Crown Prosecution Service about this.

Reports will normally be prepared for the child-protection conference; a copy of the social services report should be given to the parent (and child if appropriate) beforehand, and they should have the opportunity to discuss the contents of the report before the conference. The report should contain a chronology of significant events, information about the child's health and development, information on the parenting capacity of the parents, the direct views, wishes and feelings of the parents and the child, and an analysis of the above and consideration of the implications for the future.

The main task of the conference is to address the continuing risk of significant harm to the child. The main decision of the conference is whether or not to add the child's name to the child protection register: and, if the decision is to register the child, then certain other actions need to be taken. However, these other actions – deciding whether to implement care proceedings in respect of one or more of the children in the family, and deciding whether to prosecute the abuser – are not the business of the child protection conference. The input of the conference may be influential in making the decisions but the decisions themselves are made by the agency concerned: social services and the police respectively.

An important principle of child protection is that the act of registration in itself confers no protection on the child; it is the concerted and coordinated actions of the agencies that will serve to protect the child from future harm. Therefore, if the conference decides that the risk is continuing, it should do the following things: appoint a key worker; identify a 'core group' (professionals and family members who will work together to take the plan forward); decide how family and children are to be involved in the plan; establish a timescale for core group meetings (the first one should be within 10 working days); consider future assessments required; outline a child-protection plan (with a contingency plan); and ensure participants are aware of the different purposes of the initial conference, core group, and review conference. A date for the first review conference (no longer than three months away) should be set.

The key worker is the central coordinating link of the child-protection plan. He or she is responsible for completing the core assessment; for ensuring that a detailed child-protection plan develops from the conference plan, and that the plan is reviewed; and for leading the core group. Although the guidance does not say so explicitly, it is implicit in the key-worker role that he or she will be the one to act as the hub of the wheel of communication, informing agencies of developments, and serving as a central communication point for agencies to share their information. There should also be a written agreement drawn up with the family.

The need for an inter-agency plan has, in the past, been the criterion (along with the continuation of significant harm) for the inclusion of the child's name on the register. The child-protection plan is an action plan that indicates who will do what, by when, and why. The core assessment, begun as part of the information for the child-protection conference, will need to be completed as part of the plan; it should be completed 42 (7 + 35) working days from the beginning of the initial assessment. Where specialist assessments are required as part of the core assessment, the bringing together of the core assessment findings should not be delayed pending the result of a specialist assessment.

After the decision to register has been made, a review conference will be required. The first one should be within three months of the initial child protection conference, and thereafter review conferences should be no longer than six months apart. Review conferences, however, can be convened earlier if there are concerns warranting an earlier review. The review will consider whether or not the child's name can be removed from the register. There are three circumstances permitting this. First, if there is no longer a risk to the child. Secondly, if the child has moved permanently to the area of another authority. Thirdly, if the child becomes 18, dies, or permanently leaves the UK, then the name will be removed from the register.

Government policy states that access to services should never be a reason for a child's name to be added to the child-protection register. Likewise, when a child's name is removed from the register, the child and the family should continue to receive whatever services they have been receiving, for as long as is necessary, whilst the child continues to be a child in need.

Having outlined the child-protection procedures under the new guidance, it may be useful to look backwards a little at the findings of Gibbons et al. (1995), who investigated the matter of filtering in the child-protection

system. That is, how many cases are stopped at each of the three stages of the child-protection process: referral, conference, and registration. They found the following:

First filter: initial decision by duty social worker whether to investigate
Investigated (3/4 of referrals)
Not investigated (1/4 of referrals)

Second filter: decision by manager whether to call conference
Conferenced (1/3 of cases investigated)
Not conferenced (2/3 of cases investigated)

Third filter: decision by case conference whether to register
Registered (2/3 of cases conferenced)
Not registered (1/3 of cases conferenced)

As a result therefore of 100 referrals to the child-welfare services, only 16 would actually end up with their names on the child-protection register. The results of this filtering process have been used as an argument to suggest that too many children are being brought into the child-protection system who perhaps need not be. If it is effective, the new guidance should have an impact on that.

The legal framework

The Children Act heralded a shift towards the use of voluntary arrangements rather than compulsory intervention in efforts to protect children. Nevertheless, in cases where parental cooperation is not forthcoming or is insufficient to protect the child, compulsory measures are still required. The powers to intervene, together with the statutory controls on those powers, are contained in Parts IV and V of the Children Act 1989 and include the following orders and provisions.

Court-ordered investigations

When a court becomes sufficiently concerned about a child who is before it in connection with any family proceedings, the court may order the local authority to investigate the child's circumstances under Section 37 of the 1989 Act. To ensure the child's protection while the investigation is proceeding, the court may also, at the same time, make an interim care or supervision order and appoint a guardian *ad litem* for the child. Whether the order is sought through the court's own initiative or because of an application by a local authority, under Section 31(2) of the Act, the court may

only make a care order or supervision order if the threshold conditions (see below: 'Care order') are satisfied.

If an interim care or supervision order is made, the local authority must report back to the court within 8 weeks and notify the court of any action it proposes to take, or justify a decision to take no action.

If the threshold conditions are not satisfied the court could, either on application or on its own initiative, make any Section 8 order. There are four such orders: residence order, contact order, prohibited steps order, and specific issues order.

The orders are defined in the Act. A *residence order* is 'an order settling the arrangements to be made as to the person with whom a child is to live'. A *contact order* is 'an order requiring the person with whom a child lives, or is to live, to allow the child to visit or stay with the person named in the order, or for that person and the child otherwise to have contact with each other'. A *prohibited steps order* ('things that must not be done') is 'an order that no step which could be taken by a parent in meeting his parental responsibility for a child, and which is of a kind specified in the order, shall be taken by any person without the consent of the court'. A *specific issue order* ('things that must be done') is 'an order giving directions for the purpose of determining a specific question which has arisen, or may arise, in connection with any aspect of parental responsibility for a child'.

Care order

A care order is the only means, apart from an emergency protection order, whereby a local authority acquires parental authority for a child. Unless discharged, the order lasts until the child is 18. A care order can only be made if the conditions contained in Section 31 are satisfied: that is, if the court believes:

(a) that the child concerned is suffering, or is likely to suffer, significant harm; and
(b) that the harm, or likelihood of harm, is attributable to:
  (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give him; or
  (ii) the child being beyond parental control.

Courts are not permitted to add any conditions or requirements to a care order, with the exception of the contact that a child in care may have with parents and others under Section 34 of the Children Act 1989. Parents whose children are in care retain the right to exercise any aspect of their parental responsibility which is not in conflict with local authority decisions

regarding the child's upbringing. Under Section 34(1), local authorities have a duty to allow reasonable contact between a child who is the subject of a care order and parents, guardians and others with parental responsibility, or anyone who has had care of the child immediately before the order was made. This provision is a major reform since, prior to the Children Act 1989, parental access to children who were the subject of care orders was entirely at the discretion of the local authority. Now, however, when a care order is made, the court must satisfy itself as to the arrangements that will be made for contact and must invite comment from any interested party. Any later variation of contact which is not agreed by the parents can become the subject of an application to court (Ball, 1996).

Once the application is made and the trial venue has been decided, a guardian *ad litem* (GAL) will be appointed and a directions hearing will be arranged. The latter will usually be before a district judge at the care centre or a justice's clerk at the family proceedings court (Ball, 1996). Parties will either be present or represented, and the GAL can advise the court on matters pertaining to the child's welfare. The over-arching aim of the directions hearing is to avoid unnecessary delay prior to the matter coming to a final hearing for resolution. Thus, decisions are made about the parties to the proceedings, the expected length and timetable of the final hearing, deadlines for witness statements and the report of the GAL, the commissioning of expert medical reports, and so forth.

All reports and witnesses' statements must be exchanged in advance of the final hearing. The court must give reasons for its decision. All parties have a right of appeal. Before making an order the court must be satisfied that such a course would be better for the child than making no order at all.

Supervision order

A supervision order does not give the local authority parental responsibility but puts the child under the supervision of a designated local authority or probation officer for up to one year. The order may be discharged by the court at an earlier date or extended for up to a maximum of three years. It may contain directions that the child reside in a particular place or participate in particular activities or receive medical or psychiatric treatment.

Emergency protection order

Emergencies present a dilemma in that wide powers, available without delay, are needed to protect children in crisis situations. Someone must have the authority to immediately insist that the child is removed from a dangerous place, or remains in a safe place if threatened with removal.

On the other hand, wide powers, immediately available, are obviously open to abuse. The broadly-framed and somewhat imprecise emergency provisions contained in previous legislation (Children and Young Persons Act 1969) did allow discrepant and sometimes abusive social-work practice. As a result, the emergency provisions contained in Part V of the current legislation (Children Act 1989) are detailed and specific.

The emergency protection order (EPO) is intended for use only in real emergencies where the immediate protection of the child cannot be secured in any other way. It is intended to last for the minimum necessary time, and to be open to challenge at the earliest opportunity. Anyone (not just a statutory agency) may apply for an EPO. Application is made to a court or, with leave of the justices' clerk, to a single justice who is a member of the family proceedings panel. The order may be granted *ex parte* (without anyone who might oppose the application being either present or served notice). The grounds for an EPO are that

> there is reasonable cause to believe that the child is likely to suffer significant harm if ... he is not removed to accommodation provided by or on behalf of the applicant; or ... he does not remain in the place in which he is then being accommodated, or where enquiries are being made by a local authority, anyone authorized by them, or by the NSPCC, and they are denied access to the child. (Section 44)

An EPO may be made for up to eight days. After 72 hours, the child or anyone with parental responsibility may apply to a court for discharge of the order, provided that they were not served notice and were not present when the order was made. An EPO:

(a) operates as a direction to any person who is in a position to do so to comply with any request to produce the child to the applicant;
(b) authorises:
    (i) the removal of the child at any time to accommodation provided by or on behalf of the applicant and his being kept there; or
    (ii) the prevention of the child's removal from any hospital, or other place, in which he was being accommodated immediately before the making of the order; and
(c) gives the applicant parental responsibility for the child. (Section 44(4))

The court or justice making the EPO may add a direction requiring any other person to provide information about the child's whereabouts (Section 48(1)). An EPO may be extended once for up to seven days. It gives the local authority limited parental authority, which allows for

the making of day-to-day decisions concerning the child though parents do retain their parental responsibility subject to the EPO. There is a presumption of reasonable contact between parents and child. However, the court may set conditions about such contact and about medical treatment investigation. Children who are old enough may refuse such treatment, although in extreme cases the High Court may override the child's refusal (Ball, 1996).

Police powers

If a constable has reasonable cause to believe that a child would be likely to suffer significant harm, he or she may remove a child to suitable accommodation or take reasonable steps to ensure that the child remain where he or she is. The constable must consider the child's wishes and feelings. In addition, the constable must inform the parents, the local authority and a designated police officer inquiring into the case. Police protection lasts for a maximum of 72 hours, but during that period the designated officer may apply for an EPO, which, if granted, begins on the day that the child was taken into police protection (Section 44).

Under Section 48(9) of the 1989 Act, where it is clear that anyone attempting to exercise power under an EPO is being denied, or is likely to be denied, entry to premises or access to the child, a court or a single justice may issue a warrant authorising a police constable to exercise those powers by force if necessary.

In addition, the police have the power to enter and search any premises for the purpose of 'saving life and limb'. Where appropriate, the child could then be taken into police protection (Ball, 1996).

Recovery order

The court may issue a recovery order under Section 50 of the 1989 Act where a child who is (a) in care, or (b) the subject of an emergency protection order, or (c) in police protection, has been removed or run away from care, or is being kept away from any person who has care of them as a result of that order. The order serves as a directive to produce the child; it also authorises the child's removal by any authorised person, and permits a police constable to enter and search specified premises.

Child assessment order

The 1989 Act introduced an entirely new order concerning the assessment of a child's health and development. The child assessment order (CAO) can

only be applied for in court, on notice, by a local authority or the NSPCC where there is reasonable cause to believe: that the child is suffering, or is likely to suffer, significant harm; that an assessment of the child's health and development are necessary; and that it is unlikely that a satisfactory assessment will be made if a CAO is not made. However, if the court considers that an EPO is justified it should make such an order instead. CAOs are deemed appropriate only in those infrequent cases where a decisive step to obtain an assessment is required and informal attempts to carry out an assessment have been unsuccessful. In 1994 only 82 CAOs were made (Ball, 1996).

Having looked at some of the orders which comprise compulsory intervention it is important to stress once again that compulsory intervention is a last resort and should be undertaken only when voluntary arrangements have failed or are manifestly inappropriate (Ball, 1996).

However, research into child protection funded by the Department of Health indicates that, generally speaking, this last-resort philosophy was not put into practice. Contrary to the intentions of the 1989 Act, it seems that local authorities were initiating child-protection procedures on the basis of injuries to children, thus failing to fully consider the child's wider situation. It also appears that vital family-support services under Part III were often overlooked, with social workers instead focusing on a bureaucratic response to identified injuries. This suggests that large numbers of children were inappropriately drawn into the child-protection system. Even after it was clear that protective measures were unnecessary, the needs of such children for *services* were often left unmet (Department of Health, 1995).

Guardian ad litem

To safeguard the interests of the child a guardian *ad litem* will usually be appointed by the court. The guardian *ad litem* (GAL) is an independent social worker drawn from a panel of GALs and reporting officers administered by the local authority. The GAL is responsible for ascertaining the child's wishes and feelings and instructing the child's solicitor. In addition, the GAL advises the court on the identification of involved parties, the timetable for proceedings, and the making of interim orders. The latter includes the possible discharge of an emergency protection order. Finally, the GAL prepares a report for the court.

In cases where the child and the GAL hold differing views about the child's need, a child of sufficient age and understanding may give his or her own instructions to the solicitor. The child's solicitor then presents the child's view to the court and the GAL presents his or her own view, with legal representation where required.

The GAL's role is to provide an independent assessment of the work of local authority social workers and to make recommendations to the court, which may or may not agree with those of the local authority. Given that it is this same authority that pays the GAL's fee, it is hardly surprising that the independence of GALs has been questioned. The obvious remedy is to remove responsibility for managing the GAL service from local authorities (Ball, 1996). At present, the GAL service faces the prospect of reorganisation and integration with the divorce court welfare service.

Messages from research

A substantial body of reliable evidence on child protection and child abuse has been established over recent years. Much of this research has direct implications for policy and practice. Of particular importance are the 20 studies summarised by the Dartington Social Research Unit and published in an overview entitled *Child Protection: Messages from Research* (Department of Health, 1995). Here, we will look very briefly at those parts of the summary which shed light on the following key questions: What does the child-protection process entail? How effective is it? How can professionals best protect children?

The child-protection process

Around 160,000 children are subject to Section 47 inquiries each year. Most of the families involved in the child-protection process are multiply disadvantaged. Some 96 per cent of the children concerned remain at home, while most of those who are removed are quickly reunited with their families.

The purpose of child-protection inquiries is twofold: (a) to determine whether child abuse has occurred; and (b) to determine whether the family can benefit from support services. Unfortunately, however, inquiries usually turn into investigations, and the majority of families do not receive any services that might justify the intrusion by professionals into their lives.

Undue emphasis is placed on decisions about whether to place the child's name on the child protection register, or to remove the child's name, with insufficient attention given to supporting the child and family in the months following the case conference.

> Professionals are far less concerned with the way families are left when the enquiry is complete and concerns subside than they are with the way children enter the protection process. (Department of Health, 1995, p. 39)

Given that virtually all the children involved remain at home, it makes sense to involve the family in the child-protection process. However, the research evidence shows that professionals could do more to achieve a partnership with parents and children. For example, many investigations take place without the parents' knowledge.

How effective is the child-protection process?

The studies offer mixed findings with regard to the effectiveness of the child-protection process. There is a wide range of services for children in need. However, the authors of the overview state that: 'these should not be deployed in a way that overwhelms clients or greatly circumscribes parental responsibility or autonomy' (Department of Health, 1995, p. 44). Disturbingly, it was found that between a quarter and a third of the children studied were re-abused after child-welfare intervention, although the incidence of 'severe maltreatment' was low.

How can professionals best protect children?

Families are traumatised by a suspicion of child abuse. Therefore, good professional practice is required to alleviate the anxiety of parents and to facilitate the cooperation necessary to protect the child. The studies identify the following five pre-requisites of effective practice in protecting children and promoting their welfare:

- sensitive and informed professional/client relationships;
- an appropriate balance of power between participants;
- a wide perspective on child protection (i.e., a perspective which views cases as *children in need in circumstances where there may be a protection problem*);
- effective supervision and training of social workers;
- services which enhance children's general quality of life.

The studies found that parents were often insufficiently informed and their lack of participation (from the point of view of the social worker) frequently undermined relations between parents and social workers. Moreover, the narrowness of the social-work approach to child abuse, which reflects poor training and supervision, meant that the wider needs of children and families were overlooked.

Clients in the studies were adversely affected when professionals became preoccupied with a specific event, ignored the wider context, made the wrong 'career avenue' choice for the child, and excluded the family from the

inquiry. In the rare cases when appropriate attention was given to the 'secondary adjustment' needs of children and their families, all benefited.

Building on the existing strengths of a child's living situation is more likely to ensure effective prevention than the current approach in which 'miracles' are expected from 'isolated and spasmodic interventions'.

Effective child protection also necessitates respect for family rights. Further, basic child-care principles must be combined with specialist work to safeguard the long-term welfare of children.

In this chapter we have discussed various definitions of abuse and neglect, the causes and consequences of different types of abuse, and the child-protection system, (including the legal context). Let us now go on to explore provisions for children who are being looked after by a local authority.

Case examples

Case example 5.1 Paula Hislop

Paula Hislop is the single parent of three children, Paul James (8), Melanie James (5) and Jessica Thomas (2½). Jessica has a different father from Paul and Melanie. Paul and Melanie's dad left when Melanie was one year old, because he became involved with another woman. Jessica's dad had a very violent temper and used to be violent towards Paula, until she left, taking the children with her to a Women's Aid Refuge. She was there for six months before being rehoused into an area very far from her friends and relations. Paul appears to be a very slow learner, and the school is worried that he does not appear able to keep up with the other children. Jessica's speech has been slow to develop and she is being referred for further investigation. Her hearing appears to be normal.

After she had been in the new home for three months, Paula's neighbours became concerned because it appeared that at weekends she would go out early in the evening, and not come home until very late, leaving the children unattended. The matter has been referred to the social services.

1. Should this case be treated as one where there are children in need, requiring family-support services, or as a child-protection case? Why?
2. Regardless of whether it is a family-support case or a child-protection case, who needs to be involved and why?
3. When all professionals have been identified, consider 'How are these different agencies to be coordinated to work together?'

Case example 5.2 Jean and Paula M

Jean M (3 years, 10 months)
Paula M (2 years, 6 months)

Jean and Paula are the children of Jane M (22) and Tom M (28). They live in a private flat in the centre of a small city. Neither of them are from the area where they now live, having come here about four years ago, shortly after the birth of Jean. All of their family relations are in the area the family have come from. They have not made many friends locally, tending to keep very much to themselves. Tom moved here because of relocation with his work, but shortly after, the firm went bankrupt, and all the workers were laid off. Tom has been unemployed ever since. There are no immediate prospects for employment. The family are worried about finances because Jane is six months pregnant, but nevertheless Jane says that she and Tom are looking forward to another child. The health visitor is not sure that that is Tom's view, a result of impressions gained from the one time she met him.

Because of the relocation, Jane and Tom have no family in the area, and they have only formed friendships with two families near to them. Both of these are families being worked with by social services because of parenting difficulties. Tom has a fairly good relationship with his parents and brother, although rarely gets to see them. Jane describes there being no love lost between her and her mother, and even less between her and her stepfather.

The health visitor visits the family fairly often because she is worried about the development of the two girls, and also because she is concerned about the condition of the home. Both children are extremely low in weight and height; so low, that more than 97 per cent of children of their respective ages are taller and weigh more than they do (they are below the '3rd centile' of development for height and weight). Jane says that both of the children are difficult feeders, but that they do eat what is put before them. Tom was present when the health visitor first expressed her concerns to Jane and Tom. He reacted very angrily, saying 'Are you trying to say I'm starving my kids?' He demanded that the health visitor leave. Nevertheless, the health visitor has remained in contact with Jane and the two girls, despite Jane being a poor attender at clinic.

The home is kept in a very unhygienic and untidy state. The floors are sticky from grime and dirt. Kitchen refuse is piled in a corner of the kitchen, not in a container. Dirty clothes are littered everywhere around the house. There is often dog mess in the house caused by one of the two Alsatians that the family keep; the dogs are rarely exercised. Dirty dishes from meals are left lying around in various rooms of the house. There is no dining table *per se*, but the family eat in the sitting room, usually watching television. Generally there is an unpleasant smell within the house. There

are few toys around the house or in the children's bedroom, and those that are there are not age appropriate, being more suitable for older children.

On two occasions neighbours have complained to the local authority, because of concern that the conditions might be the cause of an increased occurrence of rats in the vicinity. An officer from the local authority visited, and confirmed that the conditions could be an attraction to rats. A specific list of recommendations/requirements was drawn up, and the family obliged … but the improvement on both occasions was short lived, before relapsing into the same conditions as before.

As regards the children's eating pattern, Jean says that she gives them their meals at set times of the day, and has described in detail to the health visitor the content of meals. The health visitor feels that if the children were actually eating everything that was described by their mother, then they would be growing better. Both Mr and Mrs M are on the slightly stout side, but not so much that one would describe them as obese.

Paula is an active, inquiring toddler, who seems to be developing normally apart from the lack of weight and height gain. She is very comfortable around people, and indeed will go to be picked up by nearly anyone who comes to the door of the home. Jean spends two mornings a week at playgroup. Unlike her sister, she is more reserved in temperament. The playgroup supervisor has observed that she is a bit behind in some things that the other children can do easily (colour and shape recognition, counting, etc.), but when given individual attention, can usually learn fairly rapidly. She loves being told stories. The supervisor has observed that she comes to playgroup in dirty clothes, has an unpleasant odour, and is always asking for food, even when she first arrives at the playgroup.

Jane and Tom have a fairly good relationship with each other, although Jane does say that Tom will go off, often for a few days at a time, without her knowing where he has gone. She tends to look up to him. Tom has never been married before, but a long-term relationship ended just prior to his meeting Jane.

The health visitor has discussed the case with the consultant paediatrician, because of the low height and weight gain, and because of concern about how the family will cope when the new baby arrives. They have decided to make a referral to social services.

- Consider what will happen next in accordance with the new government guidance.