House of Commons
Education Committee

Children first: the child protection system in England

Fourth Report of Session 2012-13

Volume III
Additional written evidence

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The Education Committee

The Education Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Department for Education and its associated public bodies.

Membership at time Report agreed:

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Neil Carmichael MP (Conservative, Stroud)
Alex Cunningham MP (Labour, Stockton North)
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Pat Glass MP (Labour, North West Durham)
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Siobhain McDonagh MP (Labour, Mitcham and Morden)
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Craig Whittaker MP (Conservative, Calder Valley)

Nic Dakin MP (Labour, Scunthorpe), Tessa Munt MP (Liberal Democrat, Wells) and Lisa Nandy MP (Labour, Wigan) were also members of the Committee during the inquiry.

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/education-committee

Committee staff

The current staff of the Committee are Dr Lynn Gardner (Clerk), Geraldine Alexander (Second Clerk), Penny Crouzet (Committee Specialist), Emma Gordon (Committee Specialist), Benjamin Nicholls (Committee Specialist), Ameet Chudasama (Senior Committee Assistant), Caroline McElwee (Committee Assistant), and Paul Hampson (Committee Support Assistant)

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Written evidence

Written evidence submitted by Jim Phillips

Further to this afternoon’s telephone conversation I have written a few notes that may demonstrate a little of my Big Picture. I have researched every aspect of childhood suffering for over 30 years, in particular plight of the vulnerable, especially the children and the aged. I have always been proactive on behalf of the vulnerable and have considerable evidence that the system is not fit for purpose—as indicated by all inquiries and the mental health disasters that seem to be avoided.

The Children Act 1989 defines “harm” as ill-treatment (including sexual abuse and non-physical forms of ill-treatment) or the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural) (section 31). “Significant” is not defined in the Act, although it does say that the court should compare the health and development of the child “with that which could be reasonably expected of a similar child”. So the courts have to decide for themselves what constitutes “significant harm” by looking at the facts of each individual case.

I suggest that the continuum of “serious harm” is not understood, eg What is “being unloved” and its effects (a severe personality disorder in some)? What is prolonged severe abuse and its effects? This then leads into the complexities of mental illness and personality disorder, dual diagnosis, paedophilia, criminal recidivism, misuse of power, even care of the elderly, etc.

Prolonged severe abuse is about 1% of the general population. There is enough international research data to substantiate this. If so, about 100,000 children are not being protected or identified.

Admission to the £200 million DSPD Programme

(http://www.dspdprogrammegov.uk/useful_information.html) was based on three factors; risk of serious harm, personality disorder and there being a functional link between the two. A candidate for the DSPD high secure units can be admitted for treatment if assessment confirms that:

— S/he is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover;
— S/he has an identifiable severe disorder of personality (defined later); and
— There is an evidential link between the disorder and the risk of offending.

DSPD was rationalised by me in 1993–94. It is a totally preventable disorder. I don’t think this obvious fact then was established in the government’s expensive programme that was recently discontinued.

http://www.familylawweek.co.uk/site.aspx?i=ed1281 The Holman judgement demonstrates that the UK’s leading experts have still got it wrong. This state of affairs will continue, but as result fewer cases will be identified, and even fewer will be prosecuted in the Crown Court. The causative dynamics of this can be demonstrated. It began before Cleveland in the late eighties. The key is accuracy and a forensically-based bedrock.

As the central funding has been reduced to LA’s everywhere everyone will suffer, especially the children and elderly who will have to suffer in silence; just as they always have. But it will never go away!

As I indicated I have information overload and have now reached the stage where a précis is near impossible. However, I will do anything to help the disempowered.

October 2011

Written evidence submitted by Nigel King

1. It is with interest that I note that the Education Committee has announced a new inquiry into The Child Protection system in England.

2. I have been involved with child protection since 1992. I was an operational detective with Child Abuse Investigations teams in North Yorkshire working with professionals in different agencies to ensure that children and young people were safeguarded. I have an MSc in Child Forensic Studies: Psychology and Law and have studied different aspects of child abuse investigation. I have reviewed in excess of 400 investigative video interviews with children and co-wrote “Child witness investigative interviews: An analysis of the use of children’s video recorded evidence in North Yorkshire”, Cherryman, J, King, N and Bull, R (1999) published in the International Journal of Police Science and Management Vol. 2, No. 1. I completed a research project titled, “Understanding the experiences of the young witness and their parent/carer in the investigation and court process”. I presented my findings to Mr. David Calvert-Smith, then Director of Public Prosecutions, who deemed this to be a model of good practice that should be encouraged nationally. In 2001 I was seconded to Her Majesty’s Inspector of Constabulary at the Home Office as a police inspector for the first national multi-agency “Safeguards for Children” inspection. I contributed to the report “Protecting children from potentially dangerous people. An Inter-Agency Inspection of Children’s Safeguards”. For many years I have been a
member of the National Executive Committee of the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN). In 2003 I retired from the police as a Detective Inspector and became an Independent Consultant and Trainer and worked with professionals and non-governmental organisations across the UK, Europe and the West Indies.

3. I believe that the major catalyst for change for child protection in England was the Report of the Inquiry into Child Abuse in Cleveland 1987. The Children Act 1989 and the national guidance set out in the “Working Together to Safeguard Children...” of the day required statutory agencies to share information and work together. Prior to this, the professionals within the principal agencies, social services, police, health and education rarely shared information or worked together. In reality professions within these agencies did not really understand what persons in other agencies did in the area of child protection. They did not understand each other’s role or problems. They all worked within their own “silos” and there was little respect or trust for workers outside their own specialism. “Cleveland” required agencies to change.

4. When I began to work in child protection in 1992, agencies were beginning to share information and work together as a matter of course and I witnessed a gradual progression to a situation where professionals, particularly with the police and children’s social care, understood each others role, respected each others skill and had trust in each others ability. This resulted in an understanding, and belief, that when dealing with child protection a multi-agency approach was essential.

5. Over the past nineteen years the child protection guidance, processes and procedures in England (and the rest of the UK) have evolved into a comprehensive and effective system. Having worked in a number of different countries and I can state that in my experience the systems in the UK are far more advanced than most other countries in the world.

6. Sadly, there have been a number of cases where systems have failed to prevent the death of children, for example:

   1945 Dennis O’Neil  
   1973 Maria Colwell  
   1984 Jasmine Beckford  
   1984 Tyra Henry  
   1984 Heidi Koseda  
   1986 Kimberly Carlisle  
   1987 Doreen Mason  
   1992 Leane White  
   1994 Rikki Neave  
   1999 Chelsea Brown  
   2000 Victoria Climbie  
   2005 Lauren Wright  
   2005 Aaron Taylor  
   2008 Peter Connelly  
   2010 Khyra Ishaq

The above cases resulted in a Public Inquiry or Serious Case Review and there would often be a change in procedures in order to improve the processes and prevent further failings.

7. I have analysed a number of the cases detailed in paragraph 6 and there are three fundamental common failings:

   1. The failure to follow agency/LSCB/national procedures or guidelines.
   2. The failure to make accurate notes or any records at all.
   3. The failure to share information.

8. I have read the Munro Review and listened to her present her findings at a BASPCAN Conference. It is my view that there was very little in the Munro Review that had not been identified in The Cleveland Inquiry, subsequent Public Inquiries and Serious Case Reviews.

9. The Education Committee are inviting written submissions to address the following points:

   — Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation);
   — Factors affecting the quality of decision-making in referral and assessment, and variations across the country;
   — Appropriate thresholds for intervention, including arguments for and against removing children from their families; and
   — Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child.

10. All the above matters have been subject of review in some form or other in the past. The Government has issued many documents and valuable guidance in these areas.

11. I would suggest that to improve the child protection system in England the Education Committee should consider the following:

   (a) Re-introduce regular visits of Health Visitors to families with children up to school age. Health Visitors are seen as non threatening professionals who are there to help mothers and ensure the
health and development of babies and young children. They are welcomed into homes and have the opportunity to monitor the environment in which the child lives.

(b) Children’s Social Care social workers have a vital role in safeguarding children. In the majority of cases they perform to a high standard, despite the pressures and heavy case load. They are required to conduct enquiries/investigations into Section 17 and Section 47 Children Act 1989 referrals. Social Work training does not adequately cover two important areas. (i) How to conduct thorough investigations, and (ii) How to communicate; build rapport and interview children and parents. Some of these parents/carers involved in child protection cases can be anti-authority, intimidating and/or difficult to engage.

c) Improve the supervision of workers by ensuring that service managers in all agencies have the capacity to monitor, support and advise their staff.

d) Ensure that staff in children’s social care, police and health who are tasked to investigate child abuse have the appropriate single and multi-agency training.

e) Ensure that all persons who work with children either in a statutory or voluntary capacity receive the appropriate awareness training and know what to do when they are aware that a child is/or suspected of being abused.

12. In conclusion, the child protection system that is in place in England is fit for purpose. It will continue to be updated and evolve. If the matters identified in paragraph 11 were addressed and everyone followed the procedures that were applicable to their role in the child protection system, kept accurate records and shared information in accordance with the procedures, more children would be safeguarded.

13. There is a cost to good training and the development of staff. However, skilled, efficient and effect staff will ensure that the child protection processes in England are followed. Children will not die through system failures and the cost of Public Inquiries and Serious Case Reviews will be significantly reduced.

October 2011

Written evidence submitted by Children and Families Across Borders (CFAB)

1. Children and Families Across Borders is the UK branch of the International Social Service Network. We are an independent charity. We work on behalf of UK Local Authorities, private individuals, solicitors and courts when social work issues cross international boundaries. The majority of our work involves child protection, children in care, trafficked children, children privately fostered from overseas, child abduction and contact disputes. We are also involved in policy and practice issues with regard to private fostering, child trafficking, witchcraft/ritualised abuse and FGM. We provide a free national advice line on international social work issues and free training for all Local Authorities which is funded by the DfE.

2. This evidence concerns the significant absence of professional expertise in social work and related professions with regard to the areas above mentioned. In none of the pre or post qualifying social work qualifications are issues such as trafficking or FGM mentioned. Therefore the very people who are charged with protecting these extremely vulnerable children have an almost complete lack of knowledge about these issues. A similar picture is true for police, education and health professionals.

3. Social work education—I submit that the social work curriculum is overhauled to reflect current practice issues. I further submit that the content of the curriculum is made the responsibility of the new College of Social Work in partnership with Universities. In this way the curriculum can be updated to reflect changing practice issues, demands and evidence based practice.

4. I would now like to address concerns in the following areas: children in care, children privately fostered from overseas, trafficked children, FGM and witchcraft/ritualised abuse. We will also comment on regional variations in practice.

**CHILDREN IN CARE**

5. There are an increasing number of Children in Care in England who have relatives overseas. CFAB are concerned that placement options overseas for children looked after are not properly investigated and promoted for these children. It is our experience that often information about these relatives is limited. If information is available, assessments are not always procured despite the child having the right to family life. We organise around 100 such assessments each year. A further concern is that assessment’s format and scope vary across jurisdictions. English courts can reject positive assessments as they do not match the format and approach of UK reports. UK Local Authorities and courts often still send UK social workers overseas despite overseas jurisdictions resenting this, it being illegal in many jurisdictions, and the MOJ and DfE advising against it. We would welcome this inquiry asking that placements overseas be more robustly promoted and that UK courts issue explicit guidance on evidence from social work professionals overseas in public law family cases.
CHILDREN PRIVATELY FOSTERED FROM OVERSEAS

6. There may be over 10,000 such children in the UK illegally. The current regulations are wholly inadequate in that they demand the private foster carer to contact the Local Authority and make themselves known. Given that the overwhelming majority of children privately fostered from overseas are overstayers on visitor visas the carers are unlikely to make themselves known. These children are generally accessing schools and health services despite being visa overstayers. There are two issues here: firstly UKRA do not track visitor visa overstayers. If you overstay there are no immediate consequences, we have no exit checks and, as a country, we do not know how many children have over stayed. Secondly, Children’s Services do not look for these children, schools do not check immigration status and Local Authorities do not proactively seek out these children. We have experience of children being in extremely unsafe placements and entering the care system when they have been left with “aunts” by their parents, or whichever adult bought them to the UK. The current regulation does not require aunt and uncles to be assessed and this has led to the “ubiquitous aunt” looking after children and places these children at greater risk because the arrangement is not monitored by social services. CFAB ask that the inquiry should satisfy itself that the present arrangements satisfactorily identify and protect this cohort of children and, if they do not, ask the Home Office and DfE to work together to effectively count these young people and then change the regulations in order to protect these children.

TRAFFICKED CHILDREN

7. Some of the children brought in as privately fostered are trafficked. Others enter the UK via a variety of means for sexual, domestic, labour and other criminal exploitation. The abuse of the visitor visa process detailed above and the absence of exit checks means it is relatively easy to traffic children into the UK. Given that frontline professionals do not have the tools to identify such children the fact that they have been trafficked often goes unnoticed by social workers even if they become known to social services for other reasons. Even when trafficking is suspected financial constraints mean social work managers can be reluctant to accept children have been trafficked despite strong evidence to the contrary. Care placements do not protect trafficked children as they are likely to try to return to their traffickers (out of fear) or be picked up by their traffickers. Specialist placements are few (Barnardos are running a pilot) as foster parents need to remove mobile phones, monitor who the child is contacting and accompany the child outside the house for at least the first month in order to prevent them going missing. If potentially trafficked children do go missing the likelihood is that they have been taken back by the traffickers. However they are treated the same as other children who go missing from care, and although they are reported missing very little is done in terms of proactively looking for them. Another issue is the National Referral Mechanism (NRM) as the vast majority of social workers have never heard of it, despite it being a duty to refer suspected trafficked children to it. Many that are aware of the NRM appear to assume that referring to it is a role for the police or UK Border Agency. The other issue is that the NRM currently sits in the Home Office and the variance in NRM decision statistics suggest that decisions on whether a child is accepted as being trafficked is as much an immigration decision as a child welfare decision. CFAB suggest the inquiry insist new practice guidelines on trafficked children be issued by the DfE. This needs to also include new guidelines on identification, placements and that the NRM be transferred to the DfE in respect of children.

FEMALE GENITAL MUTILATION

8. The critical issue with FGM is that victims are unlikely to come to the attention of child protection services for other reasons. There were estimated to be 66,000 adults in the UK who had been subjected to FGM in 2001, and this number is now likely to be much higher (DH study). These are not children who are otherwise neglected or abused. Therefore the key issue is identification. In order for potential victims of FGM to be identified then work has to be done at the borders. Often victims are taken overseas to be mutilated during school holidays, so schools are unlikely to be aware they have gone, (even if they do not go in school holidays it is optimistic to believe that schools can identify potential victims). Legislation introduced in 2005 to prosecute those adults who took children overseas to be mutilated has not been used. This is entirely due to a lack of proactive efforts to identify victims and perpetrators. There is no equivalent to the Forced Marriage Unit for FGM. CFAB are pushing for a project at Heathrow in 2012 whereby potential victims are identified at embarkation and leaflets detailing the 2005 legislation are given to adults accompanying potential victims. These travellers are then flagged so their return to the UK is picked up and the Local Authorities they live in are notified of their return and undertake a S.47 investigation. If there is sufficient evidence or suspicion that FGM has occurred, a child protection medical is undertaken and this will establish if FGM has taken place. Though this may not be a workable long term solution it will lead to prosecutions which can then be used in awareness raising regarding this issue. Longer term, an FGM unit alongside the forced marriage unity would be welcome with a remit to raise awareness in schools, health services and amongst community groups. CFAB ask that the inquiry satisfy itself that the 2005 legislation has been ineffective. If so, ask the DfE, Home Office and FCO to work together to establish an FGM unit and that these agencies work together to implement the project suggested above.

WITCHCRAFT/RITUALISED ABUSE

9. Incidences of this type of abuse are thankfully rare but children branded as possessed or witches are at significant risk of severe physical and emotional abuse and of death. As with the issues above, the lack of
knowledge amongst the child protection workforce is an issue that needs addressing. In regard to this particular area it is vital that if one child is found to be at risk then it is likely that other children exposed to the informal place of worship the branded child attends will also be at risk. It is therefore important that police and Local Authorities work together to identify all the potential victims, and that a S.47 investigation is undertaken on all children thus exposed. The most infamous UK case was the torso in the Thames case but the case of Victoria Climbie included elements of this issue and there is a current child murder case which involves this issue. CFAB ask that the inquiry consider the statutory response to this issue and recommend research and guidance to include compulsory multi agency S.47 investigations whenever this issue is suspected, that includes not only the identified child but any children who may have been exposed to the informal faith setting used by the alleged perpetrators.

REGIONAL VARIATIONS

10. CFAB offer services to Local Authorities throughout the UK, therefore we get a good overview of practice across the country. Approaches to the same issues vary markedly, as does the quality of care planning and social work practice. A useful comparison maybe the NHS where treatment pathways for given diseases are the same country wide even if the application can vary. In social work the service pathways for the same issue, trafficking, domestic violence etc, can vary widely. The organisational difference between social work and medicine is that social work falls under Local Authorities. It would be very welcome if the inquiry asked the question which Munro did not, namely; is child protection best placed as a duty of Local Authorities? It may be that child protection services are better placed in an NHS like structure where evidence based practice and service responses can be effectively implemented and will not be subject to local political variations. It is not clear that children at risk and the child protection system benefit from local political control. One would not put critical health care under the control of Local Authorities so it seems strange that this critical protective service is so placed. CFAB ask that the structure of child protection services is considered in relation to who should provide said services.

CONCLUSION

11. CFAB would welcome the opportunity to give further evidence on these subjects to the inquiry and can provide detailed case studies if required. International issues are an increasing element of the UK’s child protection services and CFAB are concerned that training, practice, legislation, guidance and structures keep pace with this.

October 2011

Written evidence submitted by Tim Loughton MP, Parliamentary Under Secretary of State for Children and Families, the Department for Education

I am writing in response to the Select Committee’s call for evidence to the Child Protection Inquiry, launched by the Committee on 14 July 2011.

On 10 June 2010, we established the Munro Review of Child Protection. This was the very first review commissioned by the Department for Education, underlining the enormous priority I and my fellow Ministers place on improving child protection and helping children, young people and families. From the start, we wanted the Munro Review of Child Protection to be different. That is why, unlike its predecessors, it was not commissioned as an immediate response to a specific incident; why it is recommending that regulation and prescription are reduced rather than increased. And, most importantly of all, that is why it was focused on the child, rather than the system. The review takes a holistic approach to child protection and bases its proposals on evidence and experience.

In her final report on 10 May 2011, Professor Munro provided a very thorough analysis of the issues, including many of the areas the Committee has highlighted as areas it wishes to examine:

— whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation;
— factors affecting the quality of decision-making in referral and assessment, and variations across the country; and
— whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child.

Professor Munro’s report looks not just at the problems, but also the underlying environment that allows, indeed sometimes inadvertently encourages, such problems to occur. The Government accepts her fundamental argument that the child protection system has lost its focus on the thing that matters most—the views and experiences of the children themselves.

The Government’s response, published on 13 July 2011, was developed in conjunction with a cross-sector Implementation Working Group. We have been mindful of Professor Munro’s advice not to cherry pick reforms and to consider her recommendations in the round, looking at the whole system.
Responding effectively to Professor Munro’s review presents significant opportunities and significant challenges. The Government is committed to continuing to work in partnership to meet those challenges. Our aim will be to create the conditions for sustained, long term reform which enables and inspires professionals to do their best for vulnerable children and their families. The Government’s response to Professor Munro’s review is the first step on the journey of reform. It adopts the principles she proposes for an effective child protection system and responds to the fifteen areas she identifies for reform.

There is now a significant opportunity to build a child-centred system that:

- values professional expertise;
- shares responsibility for the provision of early help;
- develops social work expertise and supports effective social work practice; and
- strengthens accountabilities and promotes learning.

Change will evolve and, as our response recognises, it will be possible to move more quickly on some recommendations than on others.

In order to inform the Committee’s deliberations, I am submitting Professor Munro’s final report and the Government’s response as evidence.

The Committee may also wish to take into consideration the Government’s commitment to publishing an action plan on child sexual exploitation this autumn. Officials in my department are currently developing the plan, engaging other Government departments, national and local agencies and partners in the voluntary and community sector.

I will of course be happy to assist the Committee further as the inquiry progresses.

A further two annex as submitted along with this evidence have not been re-published by the Committee as the two pieces “the Government’s Response to the Munro Review of Child Protection”, and “the Final Report of the Munro Review” are already in the public domain.

November 2011

Written evidence submitted by Dr Richard Quirk, Lead GP, NHS West & East Sussex

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child.

EXECUTIVE SUMMARY

GPs have a wealth of information and experience that they can contribute to the processes to keep children safe from harm in England. GPs and their staff are often viewed as being distant from the process as other professionals struggle to get information from practices and GPs battle between their duty of care and confidentiality to the patient and their duty to safeguard children from harm. In this brief submission I aim to highlight a few of the main challenges when trying to “work together” with GPs and their staff in child protection processes.

I am the Named General Practitioner for Safeguarding Children for three Primary Care Trusts in the South East of England. I have been in this role for two years and belong to the Primary Care Safeguarding Children Forum which is a subgroup of the Royal College of General Practitioners.

1.1 The role of general practice staff in child protection can be influential in protecting the child from harm. In this consultation response I refer to “surgeries” as a range of professionals within a surgery whom have responsibility for safeguarding children, not just the GP.

1.2 Surgeries hold significant amounts of information on children and family members which not only include health related information, but often social circumstances, history of domestic violence or drug abuse and relationship matters. Surgeries have a range of professionals who have contact with children and families including the general practitioners (GP) and practice nurses, but also the front line reception staff and administrators who have telephone and postal contact with patients.

2.1 There are a number of issues that make the surgery’s input into the child protection process more challenging.

CONFIDENTIALITY

2.2 Staff in general practice are trained in the importance of confidentiality and information sharing. The overwhelming drive of staff is to ensure that patient’s information is kept safe. A common complaint from social workers is that they are struggling to get information on children and families from the GP. The views of the surgeries are often that they have a duty to protect the confidential information of the patient and to release information would be a breach of trust with the patient. Recent documents from the General Medical Council and the medical defence unions encourage the surgery staff to act in the best interests of protecting
the child from harm and therefore to release relevant information (preferably with consent from the child or parent) when appropriate. This message is still struggling to get through and more training of surgery staff is needed to help them recognise when and when not to release information to social workers and other professionals.

Recommendation 1: That Local Safeguarding Children Boards provide multi-agency training on confidentiality and information sharing so that there is a joint understanding across agencies of when it is appropriate to share information (with or without consent) to protect children from harm.

CULTURAL DIFFERENCES

2.3 There is significant misunderstanding about the cultural backgrounds of primary care and social care. Social workers often complain that GPs are not able to attend child protection conferences (CPC) or strategy meetings. Due to statutory regulations these CPCs are held at short notice and often held at 10am or 2pm to meet the needs of most professionals who attend, GPs have their surgeries booked in advance (often a month or six weeks ahead) and contain 15 to 20 patients. If a GP were to attend a CPC there would need to employ a locum GP to cover their surgery. As GPs work as independent contractors (effectively self employed), the cost of the locum (usually £70–80 per hour) has to come out of their own pocket. The costs of attending CPCs are therefore prohibitive. This issue is ongoing and there are multiple suggestions of how to over come this. GPs could write comprehensive reports to send to the CPC, the CPC could be held in the surgery, the GP could make a conference call to the CPC to give their views and the timing of the conference could be changed to lunch times when GPs are more likely to be able to attend some or all of the CPC. A more substantial response from the government would be to fund GPs (and/or relevant staff) to attend conferences (and at the same time make it a statutory requirement for them to attend), but in this economic climate I recognise that this is unlikely.

Surgery staff often lack understanding of the culture and pressures of Social workers. Surgery staff sometimes have the view that if a member of staff has made a referral to social care then “an investigation” should take place with appropriate action. Social care staff “risk assess” the referral and often feel there is insufficient evidence to meet the threshold for further investigation and further action. They then write to the surgery staff to say that no further action will take place. Surgery staff need to understand that social care staff have to build up a body of evidence often from a range of professionals before thresholds for action are met. Surgery staff need to be more aware of the risk assessment process that social care staff use and indeed thresholds for investigation. Surgery staff need to be encouraged to continue to send referrals to social care as often individual pieces of information from a range of referrals can build a bigger picture for social care staff and make risk assessment more robust. I would suggest that a placement in social care departments ought to be a requirement during the training of GPs and practice nurses so that they have a better understanding of the culture of social care.

Recommendation 2: That the Royal College of General Practitioners be encouraged to include in their curriculum a placement in social care for all trainee GPs to understand the process of risk assessment and thresholds for intervention. Similarly Social workers should have a placement within primary care to understand the culture of general practice.

Recommendation 3: Statutory Guidance is created to clearly and explicitly detail the role of GPs (as independent contractors) in safeguarding children and to provide an explanation of how their work in safeguarding should be funded.

THERAPEUTIC RELATIONSHIP

2.4 Surgery staff have often built up a relationship with families over a number of years. They hold personal and sensitive information on patients from birth. Individual staff (eg GPs) often build up relationships with patients spanning their entire career in general practice. Patients often report that the only professional they truly trust is their GP and there is a long held belief that what they say to their GP is strictly confidential. Within this relationship is an implicit expectation that what is said in the consultation room will stay in the consultation room. When a member of surgery staff then raises a concern about a child or family they struggle with knowing when to report their concerns to other professionals. They don’t want to damage the relationship they have built with patients for fear of losing trust from the patient and potentially doing further harm. GPs and surgery staff need access to good quality advice on when to share information and support in how to handle the possible reactions they may receive from patients when they have shared information. This advice and support can come from named GPs for safeguarding children within the Primary Care Trust or social care. Easy access to these sources of advice are essential and need to be promoted to surgery staff.

THE FUTURE OF THE NHS

2.5 The pending introduction of GP commissioning and the restructure of the NHS nationally and locally risks destabilising the current safeguarding systems within the NHS. The role of the named GP, designated doctor, designated nurse and other key safeguarding roles within primary care need to be established now so that they can work with emerging Clinical Commissioning Groups to ensure that children’s safeguarding is embedded in all future commissioning of services (including adult services). We should use this restructure as
an opportunity to highlight children's safeguarding whilst structures are being created so that safeguarding becomes integral to the future of commissioning. Job insecurity, loss of posts and an uncertainty about where safeguarding posts will sit within the future NHS are all factors that will increase the risk to children as past restructures have shown that vulnerable children can fall “through the net” during service restructure.

**Recommendation 4:** The Department of Health needs to urgently define where the health safeguarding staff (eg named GP, designated doctor etc) sit within the Clinical Commissioning Groups so that they can influence commissioning intentions early in the process.

3.1 In summary GPs and their staff have a significant role to play in child protection but there are a number of factors that make this work more challenging. If there were more statutory guidance on the how GPs can play their part in child protection and how this should be funded then the contribution that they could make could make real differences to children’s lives.

**September 2011**

**Written evidence submitted by Professor Susan White (Professor of Social Work (Children and Families), University of Birmingham); Professor David Wastell (Professor of Information Systems, University of Nottingham); Dr. Geoff Debelle (Consultant Paediatrician, Birmingham Children’s Hospital); Dr Suzanne Smith (Head of Safeguarding; Pennine Acute Hospitals Trust); Dr Chris Hall (University of Durham)**

1. **Summary**

1.1 This submission relates to the work of an interdisciplinary team of senior academics and clinicians committed to the human-centred design of the child protection system in England. White served on the reference group for the Munro Review of Child Protection in England and Wastell served on the IT substream. Hall with Wastell and White undertook detailed research in children’s services and in multi-agency child welfare services on information sharing and the impact of performance management. These studies informed the Social Work Task Force and the Munro Review. Debelle has been a consultant general and community paediatrician with involvement in child protection for over 35 years. He has been lead clinician/Designated Senior Doctor in Birmingham since 1990. He is paediatric advisor to the GMC. He chairs the West Midlands Branch of the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN) and is regional representative for West Midlands Child Protection Special Interest Group (CPSIG) of the Royal College of Paediatrics and Child Health (RCPCH). Smith is Head of Safeguarding at Pennine Acute Hospitals Trust. She was the founding Chair of the National Safeguarding Children Association for Nurses and produced the “Professional Core Competency Framework for Nurses Specialising in Safeguarding Children”. Sue has experience as Independent Overview Report Author and Independent Chair for Serious Case Reviews and has provided expert guidance to the Department of Health in the development of the national programme “Leadership for Influence: Leading Safeguarding Practice”. The submission has also been sent to the Royal College of Paediatrics and Child Health to inform their own response to the call for evidence.

1.2 The submission focuses specifically on the interface between secondary health care and children’s safeguarding services, but its thesis has relevant to other settings particularly primary healthcare. It details an ongoing “action research” project, formed as a result of clinician-led innovations at The Pennine Acute Hospitals Trust (PAHT) and a range of related initiatives in Birmingham Children’s Hospital and Heart of England Foundation Trust. From December 2011 (subject to contract) funding has been secured from the National Institute for Health Research to develop further and evaluate rigorously service redesign processes intended to augment safeguarding at the hospital/community interface.

1.3 The submission also draws attention to some deficiencies and inaccurate assumptions in policy responses to previous failures in the child protection system. These well-intentioned reforms, in such a publically sensitive area, have sometimes exacerbated the underlying conditions for error in the child protection system, particular when professionals need to communicate and debate ambiguous and contradictory evidence about complex family circumstances. Safeguarding failures have frequently been attributed to two broad but under-interrogated factors: failure to “share information” and “poor multi-agency working”; these are also ubiquitous findings in serious case reviews, and the understandable response has been to prescribe more of both. This submission describes why, taken as crude categories, these assumptions are erroneous and illustrates what can be achieved if clinicians and professionals (in consultation, where possible, with children and families) design systems responsive to everyday decision-making in its human, social and organisational context.

1.4 It concludes that an approach based in the patient safety paradigm and so called “human factors” is long overdue in child protection systems nationally.

2. **Dominant Policy Responses to System Failures**

2.1 When the child protection system fails, or there are errors in professional decision-making, governments, professional bodies and other key publics naturally seek to understand why. Policy often follows quickly and leads to widespread organisational change and often the establishment of new structures of governance and accountability.
2.2 Well-intentioned attempts to make decision-making more transparent and accountable have led to a proliferation of process-oriented tasks for professionals. These systems have tended to be centrally prescribed and their design has had very limited input from practitioners. As Munro notes:

In the past, problems have too often led to more central prescription, culminating in the current over-proceduralised system. This review proposes an alternative view: that the system is complex and it is not possible to predict or control it with precision (Munro 2011: para 20).

2.3 These developments have reduced the professional time available to undertake early work with families, and crucially to communicate face to face with other practitioners and clinicians. Instead, substitutes for inter-professional relationships (such as electronic information sharing, the flagging on databases of child protection “concerns”, idealised notions of a “team around the child”) have sought to strengthen communication but have paradoxically spawned the opposite. A “team”, for instance, assembled from scratch around a child will not necessarily function as a team in any meaningful way when it comes to sharing anxieties, uncertainties and disagreements in emotionally and morally charged circumstances.

2.4 Systems designed to create an auditable paper trail have provided further conditions for faulty diagnostic explanations of failures in safeguarding, most commonly that these are due to undisciplined case recording, information sharing or multi-agency working. The policy response has been to prescribe a stronger dose of the aspects of the system that are perceived to have failed; the possibility that system failures are the consequence of such aspects is never considered. This reasoning has had a number of unintended consequences well-documented by Munro.

2.5 Attempts to increase the reporting of concerns carry their own unintended consequences: the generation of false positives, overloading child protection services, buck-passing and discrimination against disadvantaged communities. There are potentially direct adverse effects on children, for example a full skeletal survey to screen for unseen injuries can be very distressing, especially for pre-verbal infants.

2.6 We do not contend that process factors such as recording and information sharing are unimportant, or do not matter, but that they are rarely the most important causal factors when children die or are injured and that they rely on erroneous assumptions about the predictive validity of risk assessment in child protection, based on a false analogy with the use of diagnostic tests in medicine. Unlike medical conditions, serious harm to a child is often only known once it has happened, and we are then in the position of looking backwards, not forwards, for evidence after the event. Looking back, something will always be found wanting, which would seem to provide evidence of failure. This gives the spurious impression that the adverse outcome was both predictable and preventable. Quite the opposite is the case; instances of serious harm are very rare, and therefore highly unpredictable. To be sure that predictive evidence is decisive, we need to know how often it was present in cases where no calamity ensued; for example, unless it can be shown that there was a distinctive difference in the quality of assessments, information gathering and multi-agency collaboration in serious case reviews, it cannot reliably be claimed that these were critical causal features of safeguarding failures. This “false positive” rate is never assessed in social care, although its appraisal is routine in assessing the performance of medical diagnostic tests. Fallacious circular reasoning from effects to causes is endemic in the policy community and is built into the workings of the serious case review process.

3. Human Factors

3.1 If we examine in detail the human and social factors involved in cases where children are harmed and have been missed by the system a more complex picture emerges. In child health settings, clinical sense-making can be particularly complex. For example, often children present with a complaint for which there may be biological, neurological, genetic and/or psychosocial explanations; differentiating between biological and psychosocial aetiology in making diagnoses is especially problematic. Furthermore, children frequently injure themselves and the injuries may be medically trivial, creating a potential bias towards the default assumption of accidental injury.

3.2 Children are usually accompanied by parents whom clinicians may find difficult to confront and their moral evaluations of the parents can be decisive especially when the child cannot communicate directly.

3.3 Human beings have intrinsic biases in information processing (the tendencies to reach conclusions quickly and to develop a “psychological commitment” to an anchor hypothesis seeking only confirmatory evidence). Taken together these factors create a powerful force-field for case interpretations to be strong but wrong.

3.4 These pressures are challenging to counteract, resisting interventions like training which have been dominant in the arsenal of common responses to child abuse tragedies.

4. Social and Organizational Factors

4.1 In a safeguarding context, further complexities arise from the need to pass what might be unclear, speculative and ambiguous information across service boundaries. Research shows that knowledge sharing and learning are influenced by multiple interpersonal, social and organisational factors, and are inhibited by distinct types of professional knowledge, social hierarchy and low trust.
4.2 There is strong evidence from social psychology that multiagency working may have a dark side. Where there are multiple potential “helpers”, there is the propensity for no-one to help, or for others to be “left to it” especially when they are perceived to be “closer” to the problem.10 This has been ignored thus far in system design in child protection, yet it was a very strong feature of the Peter Connelly case.

4.3 Knowledge sharing throughout child health and social care is thus both “slippery” (difficult to codify) and “sticky” (difficult to share across boundaries), not readily responsive to simplistic exhortations to “share information”.11

5. THE CLINICAL CONTEXT: PENNINE ACUTE TRUST AND CLINICIAN-LED SYSTEM DESIGN

5.1 Only a thorough understanding of human, social and organisational challenges will afford effective solutions to identifying and protecting children at risk. Our submission now documents developments at PAHT which are informed by aspects of the NHS Patient Safety First initiative which, in our view, offers a much more promising paradigm based on systems thinking and human factors than the current legalistic and bureaucratised approaches followed in child protection. Patient Safety First (PSF) methods have so far made few inroads into safeguarding children in secondary health settings.

5.2 The Pennine Acute Hospitals NHS Trust (PAHT) provides general and specialist hospital treatment to a population of 800,000 in the north east of Greater Manchester. It provides emergency services, diagnostics, medicine, surgery, specialist (HIV/AIDS) and women and children’s services, employing 8,820 FTE staff. The Trust is in a process of reconfiguration under the “Making It Better” national initiative, focusing on inpatient services for women and children. Despite the existence of clear guidelines, clinical practice regarding child protection varies across the Trust sites and even within specific services. For example, there is an explicit and unambiguous requirement that children under one year of age presenting at Emergency Departments (EDs) with bruises, bleeding or fractures should be referred to the paediatrician on call, yet there are routine breaches of this protocol. In response to such failures, the Patient Safety First approach is being redesigned by the Pennine Acute Safeguarding Children Group and applied to promoting and safeguarding the welfare of children. The developments “combine bottom up energy with top down support” which has been shown to be effective in promoting cultural change.12 The intended outcome is to create a positive safety culture, characterized by openness, justice and learning, where learning from error is regarded as the norm.13 Various specific initiatives are underway.

Walkrounds. To promote an open culture when dealing with safety issues and incidents, PSF advocates the use of “walkrounds” by senior staff. This has been adapted by PAHT directly to address safeguarding issues, and is currently being piloted, before implementation across each area within children’s services and EDs. Targets will be set in order to measure effectiveness. Notes taken during walkrounds will be regularly collated and analysed feeding the findings to the Trust Board via the Clinical Governance and Quality Committee and also to practitioners through the Pennine Acute Safeguarding Children Group to achieve a “board to ward” and “ward to board” governance loop.14

Systemic incident analysis. A whole systems approach to the analysis of “safeguarding incidents” (serious failures, near misses and less consequential instances of “something going wrong”) is being developed, focusing on underlying predisposing factors (so-called “latent conditions for error”15)—those conditions which lie dormant but make errors more, rather than less likely) alongside procedural failure. Diagnostic errors and failures to communicate effectively with other professionals and agencies will be emphasised, and practitioners and managers prompted to consider how lessons learned from incidents can best be shared with peers. Congruent with a learning culture, a more robust system of peer review and clinical supervision (incorporating reflexive practice) is being developed. Application of the systems approach will be embedded within the preparation and dissemination of serious case reviews (SCRs), with progress on actions fed back through a variety of methods (newsletter, training).

Electronic reporting. The effectiveness of staff in recognising and reporting potential safeguarding risks accurately and promptly to relevant professionals from other organisations, disciplines and agencies is crucial. PAHT have a paper system for sharing information across professional and organisational boundaries known generally as a “culture for concern” form. However, the degree to which professionals consider it necessary to raise concerns differs across the organisation and across different clinical areas. A web-based tool is being designed to promote referrals that clearly express what is expected of the recipient and the level of concern.

Digital stories and service user engagement. Involving children and parents in system design in child protection is challenging, but parents who have submitted official complaints about their experience of child protection procedures within the Trust are being approached. Videos (“digital stories”) are being produced. These are presented by the parent, and are aimed at improving professional communication and helping parents to understand clinical procedures. Early experiments have shown considerable promise. Digital stories are also planned both to disseminate best clinical practice and to illustrate the root causes of critical incidents.

Co-mentoring and auditing. PSF advocates the use of risk assessment tools, and an adaptation of this is being developed within PAHT. A co-mentoring system is proposed16 which provides feedback
to staff on cases where a different intervention might have benefitted the child. This directly supports the aim of the “Munro Review of Child Protection” which seeks “a less prescriptive working environment with more room for professional judgement”. Co-mentoring will be piloted in ED, led by senior practitioners. It will focus on practice with a view to providing feedback to build trust, raise awareness, and enhance timely sharing of information. Auditing of records, as the PSF recommends, will be part of this, providing feedback when standards are not met.

Further issues

5.2 In addition to these specific interventions, other issues will be addressed and technical remedies investigated in the research. For instance, the statutory-legal approach is a dichotomous one (it is or it isn’t non-accidental injury) but clinicians have real problems with this as they see more of a continuum and that creates more uncertainty. Although diagnostic uncertainty cannot be entirely removed, it can be abated by, for instance, putting in blocks that cannot be overridden before discharge without active contemplation and exclusion of the possibility of NAI (non-accidental injury). Such simple methods are not used in the hospital setting, although similar approaches are being adopted in primary care (eg by not allowing GPs to complete a mental health questionnaire on an adult in the practice without completing the box on whether the patient has a family). At present, Birmingham Children’s Hospital rely on regular peer review of cases and have a 24/7 mechanism of obtaining advice from senior colleagues. In addition, all cases of suspected NAI must be seen or discussed by the on-call paediatrician for child protection, and the responsibilities of consultants are emphasised for children admitted under their care for NAI, particularly with respect to obtaining a second opinion and discharge arrangements. In addition to peer review, BCH are embarking on a regular clinical supervision programme for all staff undertaking medical assessments for suspected child protection, and there is mandatory safeguarding training for all staff (including dentists) involved predominantly with children. Our research will be addressing the effectiveness of these various measures.

6. Conclusion

The child protection system will never be infallible. As Munro argues, attempts to make it so have unintentionally created new latent conditions for error, by privileging efficiency, standardisation and process and by a concentration on proxies for safety embodied in performance management regimes. These may make the system feel more accountable and tractable to managers and policy makers, but they remain proxies. This submission has contended that the child protection system can be made safer by attending to human factors and some of the learning from safety-critical domains where reliability is more important than efficiency (eg aviation, nuclear power) which have been applied successfully in the patient safety initiatives. Many aspects of child protection practice can be managed with good systems, but they will only take the process so far. Organizations in which reliability is a more pressing issue than efficiency have unique problems in learning as trial and error is not available to them without dire consequences. Substitutes for trial and error come in the form of debate, challenge, the exchange of clinical/practice stories and simulations. These must be embedded in day to day practice in the way we have described.

REFERENCES


Ev w12  Education Committee: Evidence


October 2011

Written evidence submitted by the Medical Protection Society (MPS)

SUMMARY OF RECOMMENDATIONS

1. There should be clear, coherent and consistent training for all professionals involved in the child protection process across the country.

2. Such training must include an understanding and appreciation of the roles and responsibilities of different professionals involved. It is particularly important that other professionals understand what a doctor’s duties and responsibilities are, especially in respect of confidentiality and disclosure of information regarding family members.

INTRODUCTION

1. The Medical Protection Society (MPS) is the leading provider of comprehensive professional indemnity and expert advice to more than 270,000 doctors, dentists and other health professionals around the world. We have over 100 years’ experience of the medicolegal environment and operate in 40 countries around the world. In the United Kingdom we have around 170,000 doctors, dentists and other healthcare professionals in membership comprising around 50% of all doctors and 70% of all dentists.

2. As a mutual, not-for-profit organisation, we offer members help, on a discretionary basis, with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, disciplinary and professional regulatory investigations, inquests, complaints and general ethical and professional advice.

3. MPS welcomes the Education Committee’s inquiry into the Child Protection System in England, which will build on the work of the Monroe Review, and the case for other interventions made by the Field, Allen and Tickell Reviews. We recognise that doctors, and particularly doctors working in general practice, are often uniquely placed to draw information together from many different sources, that can give a vital insight into those children who are potentially at risk.

KEY ISSUES

Disclosure of information

4. MPS receives many queries from members regarding consent and confidentiality where there are child protection concerns. In our experience, the main issue for the practitioner is determining where the balance lies between the right to confidentiality and the duty to disclose to protect the safety of children. This most
often comes into play in circumstances where other agencies involved in the child protection process request the medical details and/or records of family members and/or friends who have contact with the child/children in question. An almost universal assumption by such agencies is that they have an absolute right to access any such records in their entirety, even where the person concerned has only intermittent or occasional contact with the child/children in question or only part of the notes is relevant for the purposes in question. This approach is compounded by provisions in the Data Protection Act 1998 in respect of disclosure relating to criminal activity, which is frequently erroneously cited as giving a right of access to the police and other agencies, rather than potential protection to the body disclosing the information.

5. Overall, doctors must ensure that a child’s safety and welfare is paramount and takes priority over other considerations. However the child’s family members also need to be treated with dignity and respect; therefore communication in breaching confidentiality, even where justifiable on public interest grounds is essential to maintain public confidence in the profession and optimise the benefit of data sharing, though of course there will be rare circumstances where this may not be practicable or appropriate.

**TRAINING**

6. In order to ensure that all doctors are able to play their part in the child protection process as effectively as possible, we believe that the following issues should be addressed:

(a) There should be clear, coherent and consistent training for all the professionals across the country. Despite the significant improvements that have been made in this area, our experience is that the level of training and expertise remains patchy and can sometimes lead to misunderstandings or a sub-optimal co-operation in working between different professionals in this area.

(b) Such training must include an understanding and appreciation of the roles and responsibilities of different professionals involved in the child protection process. It is of course vital, that all doctors understand and comply with the General Medical Council’s guidance in respect of child protection (new guidance in this area is currently in draft form). However, we believe it is equally important that the guidance is widely available, easy to find and access and that there is a proper appreciation by all those involved in the child protection system. It is particularly important that other professionals understand what a doctor’s duties and responsibilities are, especially in respect of confidentiality and disclosure of information regarding family members.

7. We believe a proper understanding of the obligations the General Medical Council places on doctors will facilitate a greater understanding by other professionals, and also ensure that where disclosure of otherwise confidential information may be necessary, that appropriate information is passed immediately to the doctor or doctors concerned, so that disclosure can be made as swiftly and efficiently as possible.

8. We do not believe it is in anybody’s interests, most particular the interests of any child that might be at risk, for doctors to be asked for wide disclosure of confidential information, without being provided with the information they need in order to comply with General Medical Council guidance. This can place doctors in the invidious position of having to request further information, in order to properly consider the request for disclosure which can sometimes lead to unnecessary and frustrating delays, as well as potential misunderstanding and friction between the professionals involved.

9. We believe that the process could be smoothed and made more effective by better training in this area and would strongly urge the Committee to make appropriate recommendations to address this issue.

*September 2011*

**Written evidence submitted by Ian Joseph**

1. The UK is the **ONLY** country in Europe (apart from Croatia and perhaps Portugal) to tolerate the practice of forced adoption. The severing of all contact FOR LIFE between children and their birth parents. In effect a LIFE sentence without the opportunity of being heard by a jury, often imposed on parents who have committed no crime but who are said to be a risk to their children following predictions by “experts” working closely with the local authority.

Yes the UK family courts then mete out “PUNISHMENT WITHOUT CRIME” The ONLY people in the UK who are punished without crime are parents whose children have been “confiscated” by the hundreds, because those children are said to be “at risk” of emotional abuse!. The Family Courts presume parents are guilty of abusing or neglecting their children unless they can prove their innocence (which rarely happens!).

2. Even worse the UK is the **ONLY** country in the world to GAG parents who wish to protest publicly when their children are taken.

The right of all citizens to protest publicly against what they perceive to be oppression by the State is what separates democracy from tyranny.

Long may it remain so!
3. Are there really parents who are punished by the State when they have committed no crimes?? YES!! The ONLY people in the UK who suffer this injustice are parents whose children are taken away after so called “experts” make predictions of the future such as “risk of emotional abuse”. Most mothers would receive better and fairer treatment from the court if they killed their children (and benefited from the protection of criminal procedure) rather than tangle with the cold ferocity that demolishes 99.75% (judicial statistics) of the unfortunate parents who appear before the stern “establishment” judges sitting in our UK family courts. In other European countries such as France, Spain, and Italy, where “the family” is almost “sacred” they just cannot believe the behaviour of social workers in the UK when they take newborn babies from their mothers for “risk of emotional abuse”, a concept completely unknown on the continent. Indeed the whole idea of “emotional abuse” is met with incredulity!

4. The three essential reforms we need are:
   (A) Freedom of SPEECH for parents at all times.
   (B) Final hearings to be heard by JURIES.
   (C) An end to the Punishment of parents who have not committed any CRIME.

Punishment Without Crime!!!

5. The nightmare begins when social workers act like a second police force PUNISHING PARENTS who have NOT committed any crime. They do this by obtaining an emergency protection order “ex parte” (in the parents’ absence) to take away children into foster care. They claim these children have “suffered emotional harm” or worse still are “at risk of emotional harm”! On this basis an order is nearly always granted without any problem by a “friendly” magistrate. They then pressurise the parents with threats that if they do not “do what we tell you” or if they dare to discuss “the case” with their children or tell them “we love you and miss you” during “contact” the social services will stop contact and maybe never let those parents see their children again etc. Parents are GAGGED when speaking to their own children!

6. Even worse, when issuing INTERIM CARE ORDERS the “Family courts” have become “Kangaroo courts”. Interim care orders are issued on the basis of written statements from social workers and “hired experts” that cannot be questioned or disputed because these documents are not shown to the parents and in any case the authors are nearly always absent from court! The parents are rarely allowed to testify as not only the judge but also their own lawyers nearly always stop them from speaking! If they do by some miracle manage to testify, what they say is not only disbelieved it is almost always completely ignored! The interim care orders are usually renewed automatically every month for nearly a year before a final care hearing is held, during which time the unfortunate children are isolated and sometimes alienated from their parents due to very limited supervised contact periods wondering what they have done wrong!

7. “Legal aid lawyers”, usually advise clients to “go along with social services” earning their fees the easy way! Those few parents who succeed in winning and recovering their children are nearly always those who represent themselves. When this happens however judgements, court documents, reports from experts, and position statements are often shown to parents at the last moment or not shown to them at all! As a consequence, when local authorities apply for an interim care order in the family courts only one in 400 is refused! (official judicial statistics), so what chance do most of the unfortunate parents have?

8. To cap it all social workers only too often, go round schools and friends of parents and, by their loaded questions spread harmful rumours about the parents. The unfortunate parents however are warned (quite wrongly in fact) that they are forbidden to talk to ANYBODY about their case (they actually CAN talk to individuals for advice and support) Those bold enough to protest publicly, or otherwise break gagging orders are jailed in private for their impertinence (200+ per year according to Harriet Harman answering a Parliamentary question, when she was minister for children). Yes parents are legally GAGGED yet again, when their babies and toddlers are taken to protect the “privacy” of families and children! Grandparents, aunts, and uncles are excluded from the court in order to “protect the children’s privacy!” Social services however have no need to respect this “privacy” as they frequently advertise for adoption the children they have taken, with colour photos and first names in the Daily Mirror and other periodicals, much to the horror of parents when they see their offspring paraded for “the public to choose” like pedigree dogs!

9. Eventually many of these children get adopted (“Forced Adoption”) and their siblings are often split up into different families despite the pleas of their parents who have been judged to pose a “risk of emotional abuse” to these babies and young children. Alone in Europe, only the UK (and maybe Croatia and Portugal) tolerates forced adoption of children against the wishes of parents in court. In most cases, the parents never see or hear from their children for the rest of their lives, so these children are cut off for ever not only from their parents, but also their grandparents, aunts, uncles, cousins and quite often also from their own brothers and sisters! The parents (and their children) are in effect punished not for something they have done but for something some “expert” (using a crystal ball?) thinks they might do in the future! Babies and young children who have been battered and physically abused (like baby P) are “poor adoption material” and no use to social workers hoping to “hit” their adoption targets, (PAF C23 Ofsted) so they are more often than not left to die alone...
10. Children however, with just ONE unexplained injury such as a bruise, a burn, or a fractured arm but with no prior record of abuse or injuries still make good adoption material and are seized for that purpose even when there is no evidence that the parents were in any way responsible. IT’S “ONE STRIKE AND YOU ARE OUT”. That is the cry of the “SS” and is typical of the way that “justice” is served up at our UK family courts!

11. This is the REALITY of what actually happens to parents falling foul of the “system”. Is there a conspiracy? No need! Lawyers, fosterers, “experts”, adoption agencies, social workers, and even judges all do very nicely out of the present system and have no need to conspire but naturally they do unite to resist, to COVER UP any mistakes they may have made if anyone threatens to “rock the boat”!

12. What reforms should the government introduce? Well, the social workers in “child protection” must be ordered to pass their enforcement functions back to the police, who should only remove children if crimes have been committed by parents that could adversely affect their capacity to care for the children. The family courts should adopt the rules of evidence that govern procedures in the criminal courts where fair and just rules of evidence now prevail. That is how it used to be before the Children Act 1948 when police and criminal courts(not social workers and family courts) dealt with removal of children from cruel or neglectful parents, and it worked much better! Parents would have the right to question their “accusers”, demand final hearings by juries, and would no longer be gagged. Parents should no longer threatened with jail if they complain publicly when their children are taken, and should no longer be threatened with having their contact sessions with their children in care stopped if they dare to discuss their case with them. The Children Act 1989 should be amended to remove all gagging of parents wishing to discuss publicly matters concerning their children or to talk about their case with those children. There would then at last be an excellent chance that most of these injustices would be eliminated.

13. Yes family courts should be criminal courts and children should only be taken from parents if they have committed or been charged with a crime. At the moment however babies are snatched at birth from perfectly inoffensive and law abiding parents for “risk of emotional abuse”. This accusation is the social worker’s “favourite” as it is quite impossible for parents to prove their innocence when so called “experts” predict what they might or might not do at some time in the future! Incredibly, mothers lose their children to forced adoption not for anything they HAVE done but for what some “experts” (reading tea leaves or tarot cards?) predict they might do!

YES IT’S PUNISHMENT WITHOUT CRIME!!

14. Even the actual family court proceedings are fatally flawed. Only too often parents resisting a local authority application for an interim care order are faced with reports from social workers and “experts” who do not come to court and so cannot be questioned. Barristers read these reports as though they are themselves witnesses and present these reports made by absent officials and experts as though they are “gospel truth”. When the parents contradict them with live evidence in court the hearsay evidence coming from the local authority barristers is nearly always preferred! Furthermore, when the local authority employs an “expert” to rule on parents’ mental state, non accidental injury to a child, or parents’ general parenting skills those parents are routinely refused by a judge the opportunity to call experts of their own to counter those “expert opinions”. The result is that parents are then faced with reports by these experts who rarely turn up in court to be questioned. The parents are then informed that they have no qualifications so when the local authority’s expert says they are not fit parents, then that is the evidence that must be believed!

15. The theory is that “adoption targets” (still very much in force via Ofsted PAF C23) are set to encourage social workers to find children languishing in care for years new permanent homes. The reality however is that adopters want babies not older children so social workers seize babies and toddlers to be put into care and from there into forced adoption with the agreement of compliant judges so that targets can be met!

Disgracefully in our family courts all the rules of evidence are casually “thrown out of the window”. SHAME on our family court legal system and all those who support it!

EXAMPLES OF HOW RULES OF EVIDENCE HAVE BEEN DISCARDED IN THE FAMILY COURTS WHEN GRANTING INTERIM CARE ORDERS

16. (1) Statements from the local authority are shown to the judge but rarely to parents. Family and friends of parents are routinely excluded from the court but groups of social workers are allowed to stay in the court to listen to their colleague’s testimony whether they are witnesses or not.

(2) Parents representing themselves are denied the opportunity to cross examine witnesses appearing against them. Judgements, reports from experts, and position statements are either withheld or given to parents at the last minute (too late to read and analyse them properly).

(3) Parents are routinely refused permission to call for a second opinion when “experts” and Doctors have testified against them. If parents record contacts with their children, or interviews with experts or social workers judges routinely refuse permission for these recordings to be heard yet they always allow recordings and video evidence to be heard if produced by police or social workers.
(4) Parents whose children have been taken are routinely and wrongly told that they may not talk to ANYONE about their case.

(5) Parents are jailed if they protest publicly when their children are taken. They are also jailed for “breach of the peace” or “harassment” if they dare to trace and then contact their own children after adoption. Parents are therefore “twice gagged” contrary to the Human Rights Act, Article 10 entitling all persons “freedom of expression”, ie freedom of speech.

(6) Local authority barristers in court often read out statements from absent persons as though they are themselves witnesses but they cannot be questioned.

(7) Most solicitors refuse to let their clients speak and then agree to all care orders demanded by social services.

(8) Judges routinely castigate parents who wish to speak or who represent themselves even though they have the right to do so; their evidence and their arguments are usually ignored in the judgements.

(9) Parents representing themselves are often given an hour or two’s notice to appear in court but solicitors are given weeks!

(10) Parents are punished for “risk” ie not what they have done but for what they might do in the future! “Risk of emotional abuse” is favourite because there is no legal definition of this and it is usually impossible for parents to defend themselves against “predictions” by so called “experts”.

(11) Judges give social workers the power to withhold parent’s contact with their children “in care” as a punishment for saying they love them and miss them or that they are fighting to get them back. They use this power to gag parents and force them into complete submission!

(12) Parents are in effect condemned for offences against their children on “probabilities” 51% instead of beyond reasonable doubt.

(13) Parents who were themselves in care or who were abused in childhood are often judged unfit to be parents as a result.

(14) Parents often forfeit their children for “failing to engage with professionals”.

(15) Parents faced with forced adoption lose their children for life, without being allowed a hearing by jury.

(16) Under the UN Convention on children’s rights children have a RIGHT to be heard in court but are usually denied that right.

(17) Solicitors routinely tell client parents to agree to interim care orders or they risk never seeing their children again. A lie!

(18) Social workers are legally obliged to place children with relatives if possible but either ignore this or find pretextes to fail them on assessments.

(19) Human rights to free speech and freedom of movement are breached by gagging orders and confiscating parents’ passports.

(20) Parents are routinely forbidden to call witnesses on their behalf contrary to human rights. Family and friends are wrongly prevented from entering the court.

Extract from “The Times” 13 April 2010!

17. Lord Justice Wall (The Senior family court judge) said that the determination of some social workers to place children in an “unsatisfactory care system” away from their families was “quite shocking”. In a separate case on which Sir Nicholas Wall also sat, Lord Justice Aikens described the actions of social workers in Devon as “more like Stalin’s Russia or Mao’s China than the West of England”!

http://business.timesonline.co.uk/tol/business/law/article7095791.ece

Family torn apart in 15-minute court case by Judge James Orrell ...

18. Lord Justice Thorpe said on Appeal “I am completely aghast at this case. There is nothing more serious than a removal hearing, because the parents are so prejudiced in proceedings thereafter. Once you have lost a child it is very difficult to get a child back.” The hearing lasted only 15 minutes after a doctor “expressed the opinion” that bruising in the ear of one of the three children looked as though it was caused by pinching. The parents were not allowed to give any evidence! Their three children had all been forcibly removed until they were ordered to be returned by Lord Justice Thorpe on appeal.

19. If the three family judges above describe the family courts respectively as “shocking”, “more like Mao’s China and Stalin’s Russia”, and “prejudiced against parents” who would care to contradict them?!!

(1) The UK is the ONLY State in the WORLD that gags parents whose children have been taken by social services.

(2) The UK is the ONLY State in Europe (except Croatia and possibly Portugal) to permit the horror of “forced adoption”.

(3) The UK is the ONLY State in Europe to allow “Punishment without crime” ie the taking of children by social services from parents who have not committed any criminal offence.
(4) The UK is the ONLY State in Europe taking children for “emotional abuse” and worse still “risk of emotional abuse” (on the basis of predictions from overpaid charlatans that one day parents just might harm their children).

(5) The UK is the ONLY State in Europe to censor conversation between parents and children in care. Children are left wondering what they have done wrong as parents are forbidden to explain the situation, or discuss the court case in any way. Phrases such as “I love you and I miss you” are also forbidden under the threat of contact being stopped immediately if the parents “transgress”. Children naturally begin to think their parents might not love them or want them back anymore.

20. All this is a disgrace to democracy and a disgrace to freedom that could be instantly rectified by legislation to make all the above five practices illegal and to allow parents threatened with permanent separation from their children to demand a hearing by a jury.

October 2011

Written evidence submitted by Children Are Unbeatable!

BANNING PHYSICAL PUNISHMENT IS ESSENTIAL FOR EFFECTIVE CHILD PROTECTION

1. This submission touches on all four points of the Committee’s inquiry but primarily on the first, regarding effective early help to children at risk.

2. We submit that children are not effectively protected in this country while the law continues to allow them to be violently punished by their carers. Most child abuse deaths are from physical assaults, of which a significant number are perpetrated in the context of physical punishment (the exact proportion is unknown, because analyses of serious case reviews do not investigate this factor). Many children would be saved from abuse if social workers and those working with troubled families could tell parents that the law forbids them to hit their children; indeed children themselves might be empowered to speak up if they knew that this was the case. There is nothing good about physical punishment and much that is bad.

CHILDREN DEATHS INVOLVING PHYSICAL PUNISHMENT

As well as Victoria Climbié and Peter Connolly, examples include:

Heidi Koseda (died 1984) Four year-old beaten and starved to death by mother’s boyfriend, who was punishing her for “being greedy”.

Kimberley Carlile (1986) Four year-old imprisoned and beaten by her stepfather for “being naughty” and refusing to accept him as her new father.

Liam Johnson (1987) Three year old beaten to death by his father, Robert Johnson. Johnson’s girlfriend later said, “He was so powerful that when he smacked his sons he sometimes knocked them off their feet.”

Sukina (1988) Five year old beaten to death by her father because she was unable to spell her name, first with a ruler, then plastic tubing and finally with a kettle flex. As she was dying she told her father she was sorry.

Leanne White (1992) Three year-old beaten to death by her mother and her boyfriend. A neighbour reported Leanne’s screams and the boyfriend saying, “If you do that again, I’ll thrash you.”

Lauren Wright (2000) Six year-old beaten to death by her stepmother. People in her village had seen her being hit, but felt powerless to intervene.

Carla Nicole Bone (2002) 13 month-old murdered by her mother’s boyfriend, who was “disciplining” her for refusing to walk. He told the police it started with “not-excessive smacks… It was the way I was brought up. It never did me any harm.”

Kieran Edwards (2007) 21-month year-old who died after being shaken and struck by his step-father because he was “messing about and struggling”.

3. Children Are Unbeatable! (CAU!) is the largest ever alliance on a children’s issue in the UK. It seeks complete removal of the “reasonable punishment” defence and to promote positive non-violent forms of parenting. These aims are supported by over 600 organisations and projects, including all the main child protection organisations.

THE ISSUE NO-ONE MENTIONS

4. In the child protection world physical punishment is, to use a tired cliché, the elephant in the room. Neither the Munro nor the Allen report mentions the issue, nor (less surprisingly) do Field or Tickell. In the last decade the government issued numerous reports, leaflets and guidance on child protection—including a rewriting of Working Together to Safeguard Children that nearly doubled its length—but not one of these documents discusses physical punishment, despite the fact that a new law on the “reasonable punishment”...
defence was actually introduced in the 2004 Children Act (section 58). Though both the tragic deaths of Victoria Climbié and Peter Connelly involved savage physical punishment, the two related inquiries by Lord Laming made not a single reference to the topic, despite many submissions urging prohibition.

5. We anticipate that only a few CAU! members will raise the issue in their submission to this Committee, not because they do not support prohibition (many have run strong campaigns and programmes of their own against physical punishment) or because it is irrelevant to child protection. They will not raise it because, having been ignored for so long, they are pessimistic that they will be listened to on the subject.

6. Our submission focuses on child protection but we remind Committee members that, regardless of the evidence, children have a right to the same legal protection from assault that adults enjoy. This right is recognised in recommendations to successive UK Governments by many human rights treaty bodies.2 Worldwide, thirty countries have now enacted full legal prohibition, 16 of which are EU members. A further seven have made a commitment to enact full prohibition in the near future which leaves only four EU members resistant to law reform (the UK, Belgium, France and Malta).

7. We urge the Committee to have the courage to recommend full legal prohibition of all forms of physical punishment as a child protection measure (as the Joint Parliamentary Committee on Human Rights did in 2004 and the Health Committee in 2003).3

WHY THE “MILD SMACK” IS RELEVANT TO THIS INQUIRY

8. We predict that some Committee members will say: “But the current law now prohibits everything except the most trivial smacks and these have nothing to do with child abuse.”

9. We agree that occasional smacks delivered in a loving context are entirely different to serious assaults. Nonetheless both are violent, painful acts perpetrated by carers as a punitive measure and therefore have some relationship to each other. While the occasional smack may not harm a child’s development, for some parents (though not all parents) there is a documented risk of “legal” smacking escalating to severe and frequent physical punishment.

THE LETHAL ESCALATION FROM SMACKS TO SEVERE ASSAULTS

10. In 2002 Elizabeth Gershoff conducted a meta-analysis of 88 studies on the effect of “ordinary” corporal punishment, specifically excluding studies on “abuse” (ie severe assaults) which she updated in 2008.4 This found a strong consensus on physical punishment’s many negative outcomes, including weak internalisation of moral standards, increased child aggression, violence in later life and poor mental health.

11. The only apparently “positive” aspect of physical punishment identified was that physical punishment could be effective in gaining the child’s immediate compliance (though it was not the only sanction which did this). Ironically this proves to be smacking’s most dangerous feature. Because, though it may stop children misbehaving in the short term, research also finds it fails to make them behave in the long term so children must be smacked again and harder when they repeat the misbehaviour. Many parents step back from the escalation trap; it is unfortunately often the most hard to reach parents who progress from smacks to more serious forms of violence.

EVEN THE LIGHTEST SMACK IS NOT SAFE

12. The tiny group of “pro-smacking” researchers (almost all from Christian colleges in the United States) do not now claim that smacking is a necessary form of discipline, they simply say that there is no evidence that “safe spans” do harm.5 (“Safe spans” are defined as open-handed smacks on the bottom or extremities of a child aged between two and seven, so long as they are not perpetrated in anger or stress or over-frequently.)6

13. While it is true that the occasional light smack does not necessarily cause lasting harm, there is no such thing as a safe smack. All smacks carry some risk of causing unintended physical injury, for example because

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3 Joint Committee on Human Rights Nineteenth Report 8 September 2004; Health Committee Sixth Report 5 June 2003, paragraph 55.


5 One exception is a study by Marjorie Gunnoe from Calvin College, Michigan, which has been given disproportionate media attention in the recent period. This claimed that to show that children who were smacked between the ages of 2 and 6 were more likely “to do well at school, do more volunteer work and go to university” than those that were not. In fact this research, which failed peer review, studied the self-rated behaviour of 177 high school students (of which only 42 said they had not been smacked); insofar as it showed anything, it showed that smacking after the age of six was likely to make children significantly more violent.

an unsteady toddler gets knocked over or a blow accidentally hits head or stomach. Smacking children may also impact on their sexual development—hardly surprising when one considers that smacking often involves loved parents hitting their children’s erogenous zones in an atmosphere of heightened passion.7 Probably the most fundamental danger of the parental smack, even a light one, is that it tells the child that hitting and violence is legitimate behaviour in inter-personal relationships. Surely this is the last message we want to send children?

THE WEAKNESS OF SECTION 58

14. Section 58 of the Children Act 2004 permits the defence of “reasonable punishment” for a common assault on the child. Any parent or person acting in loco parentis may use the defence of “reasonable punishment”, regardless of parents’ wishes in the matter, so long as they are not specifically prohibited from doing so.8 The defence is not available for injuries which cause actual bodily harm (ABH). The Crown Prosecution Charging Standard advises that where the victim is a child or vulnerable adult, a common assault may be changed to ABH “where an assault causes any…injuries… other than reddening of the skin, [though] the injury [must] be more than transient and trifling.”9

15. Common assaults potentially include punishments which cause pain or humiliation but not injury, for example forcing children to maintain painful positions, making them eat unpleasant things or even, according to Court of Appeal judges, giving them a kick.10 In addition, assaults that risk serious injury but do not actually cause it, such as blows to the head, ears, kidneys or genitals, are common assaults not ABH. Nor can frequency change a common assault to ABH, so children can be smacked many times a day with impunity. In short, as an attempt to draw a line between acceptable and unacceptable forms of physical punishment, section 58 plainly fails.

16. Prevalence studies show that most children in the UK experience physical punishment and that an alarming number suffer serious assaults from their carers.11 However, there have been virtually no prosecutions involving section 58. In 2007 the Crown Prosecution Service (CPS) reviewed the small number of cases in which physical punishment was involved after section 58 had come into force.12 Of seven cases, all involved serious assaults like punches or slaps around the head and all the defendants avoided conviction. A second survey found that there had been no recorded cases at all involving section 58 between 2007 and 2009.13 It is clear that it is alarmingly difficult to get a conviction in British courts for assaults inflicted in the name of physical punishment.

SECTION 58 UNDERMINES CHILD PROTECTION

17. Section 58 is almost impossible to justify in the context of child protection. Aside from danger of escalation (see above), the existence of section 58 also undermines effective child protection because:

— It permits an arbitrary level of violence which invades children’s physical integrity, making it a potential pathway to more serious physical or sexual abuse;
— professionals working with families are unable to deliver clear messages that hitting and hurting children is not allowed;
— children do not complain about something they are told is permitted and justified;
— those witnessing violence to children have no confidence in either intervening themselves or reporting it to the authorities;
— parents are receiving confusing messages about the legitimacy of hurting their children;
— section 58 fails to protect children from painful, dangerous, humiliating or frequent assaults and sends them the message that hitting people is acceptable.

7 See for example Ian Gibson, 1978, The English Vice: Beating, Sex and Shame in Victorian Britain and After Duckworth. Murray Straus has also recently produced alarming evidence suggesting that corporal punishment in childhood is closely associated with coercive sex in later life—see http://pubpages.unh.edu/~mas2/CP-Empirical.htm
8 Following concern about legal assaults in Madrassas, Sir Roger Singleton recommended that the defence be limited to members of the child’s household (which includes parents’ sexual partners, nannies, lodgers, step-parents, private foster-carers, relatives etc). Sir Roger Singleton Physical punishment: improving consistency and protection (2010) http://www.education.gov.uk/publications/eOrderingDownload/DCSF-00282–2010.pdf
9 Crown Prosecution Service, Offences against the person, incorporating the Charging Standard, guidance October 2009 http://www.cps.gov.uk/legal/1_to_4/offences_against_the_person#P73_2396
12 http://www.cps.gov.uk/publications/research/chastisement.html
Child Protection Outcomes in Countries That Have Banned Physical Punishment

18. Many of those involved in safeguarding responding to the then Government’s review of section 58 in 2007 argued that this law weakened child protection. The vast majority thought that the new law was unhelpful to children at risk and only 1% of respondents overall believed that children’s legal protection had been improved by the new law. \(^{14}\) 29 Local Safeguarding Children Boards (LSCBs) have now signed up to the aims of Children Are Unbeatable!

Why Physical Punishment Has not been Banned

19. The experience of countries that have outlawed corporal punishment strongly suggests that banning physical punishment improves child protection.

20. Sweden was the first country to enact a full ban, in 1979. When the law was passed in 1979 the government undertook to commission regular independent research and in 2009 the Swedish Government published a booklet summarising this research. \(^{15}\) It shows that the use and acceptability of physical punishment radically declined in Sweden over this period. Reporting of suspected abuse, however, rose and the booklet comments: “Opponents of law reform… use these figures to suggest that banning physical punishment increases child abuse. But this increase in reporting reflects the fact that tolerance of assaults on children has decreased, so people are more willing to inform the authorities about suspected cases.” It points out that, first, prosecutions for assaults did not increase over the period and second: “Interviews with parents in 1980, 2000 and 2006 reveal a sharp decline in the more serious forms of physical punishment, such as punching or use of implements.” Nor did the ban increase civil interventions as numbers of children entering care declined over this period.

21. New Zealand is the only English-speaking country to have banned smacking, in 2007. Because of public anxieties, the law explicitly states “the Police have the discretion not to prosecute complaints …where the offence is considered to be so inconsequential that there is no public interest in proceeding with a prosecution.

The Government undertook to ask the police to collect periodic data on prosecutions of parents. In November 2009 a ministerial report confirmed that this showed, though there had been a rise in the reporting of violence generally, parents had not been prosecuted for “light smacking.” \(^{16}\) Surveys also show a decline in the use and acceptability of physical punishment by New Zealand parents. Despite a citizen-initiated referendum in 2009 against the smacking ban, the incoming Conservative government decided to retain it.

22. As regards other European countries, a study carried out between October and December 2007 examined 1,000 parents in each of five European countries: Sweden, Austria and Germany, which have prohibited corporal punishment, and France and Spain which had not prohibited corporal punishment at the time of the study (Spain prohibited all corporal punishment in December 2007). \(^{17}\) Nearly all forms of corporal punishment were used significantly less in countries which had prohibited than in those where it was still lawful. Alarming, nearly half of the Spanish and French parents said they had used severe corporal punishment “a resounding slap on the face, beating with an object or severe beating” on more than one occasion, compared with 14% of Austrian and German parents and 3% of Swedish parents.

23. It is reasonable to wonder why physical punishment was not banned decades ago. We believe there are three main reasons:

(1) Because of political caution. Polls tend to show the majority of parents do not support a ban and influential newspapers—particularly The Mail and The Sun—have opposed it. A small minority of fundamentalist Christians run energetic and well-funded lobbying campaigns. It is not surprising that successive Governments opt to do only the minimum necessary about such a tricky issue.

(2) Because physical punishment is a part of British culture (as it is a part of most cultures) and deeply rooted in our psychological make-up. Since it relates to how we were raised in childhood and how we parent our children, the issue involves emotions as much as intellect and our objectivity is hampered.

(3) Because of a strong and understandable reluctance to interfere with private family life. A ban is seen as ‘nanny state’, undermining parents’ self-confidence and autonomy, potentially criminalising every parent who inflicts a mild smack.

\(^{14}\) (Department of Schools, Families and Children, Section 58 of the Children Act 2004 Review (consultation) Analysis of responses to the consultation October 2007)

\(^{15}\) Never Violence—Thirty Years on from Sweden’s Abolition of Corporal Punishment http://sca.savethechildren.se/Documents/Resources/never%20violence.pdf

\(^{16}\) Hughes P, Chief Executive Ministry of Social Development (2009) Report to the Minister for Social Development and Employment: pursuant to section 7(2) of the Crimes (substituted section 59) Act, New Zealand Ministry of Social Development.

\(^{17}\) Bussmann, K. D. (2009) The Effect of Banning Corporal Punishment in Europe: A Five-Nation Comparison, Martin-Luther-Universität Halle-Wittenberg
...AND WHY THESE ARE NOT SUFFICIENT REASONS

As regards these reservations:

24. A political issue. We believe that the political climate has changed. While no doubt there will be an energetic lobby against a ban, it will be small in numbers (few people enjoy defending hitting children); on the other hand there is now an impressively large and influential body of individuals and organisations who would give the Government strong support if it took this step—for example all the relevant Royal Colleges, all the parenting organisations and many mainstream religious groups and religious leaders.18 If the Coalition Government proposed a ban a physical punishment it is highly doubtful whether the Labour benches—deeply conflicted about the issue when in power—would oppose it.

25. Parental views on the issue are changing. This will always be a controversial issue but fewer parents now see smacking as necessary and when provided with information, many shift their opinion to supporting a ban.19 However, while it remains legal parents will continue to hit their children. It is an issue where governments need to lead, not follow, public opinion.

26. An emotional issue. Most members of Children Are Unbeatable! were smacked by their parents and have smacked in their turn and have had to overcome their own emotional programming. They support the campaign, not to persecute or guilt-trip parents, but to move society on, just as we moved on from a society where women could be beaten by their husbands and servants by their masters.

27. A private family matter. We note that David Cameron said recently that government should be “less sensitive” to claims that intervening in families was “interfering or nannying”.20

28. As regards “criminalisation” of parents, while it is true that when children are given the same rights under as assault laws as everyone else then even a mild smack will technically constitute an assault. However it is not true that their parents would find themselves in the criminal justice system, any more than an adult who mildly smacks another adult does.21 Trivial assaults are a waste of police and prosecution time (the de minimis principle), not in the public interest and therefore not pursued. Where the victim is a child action would be even less likely because the child’s best interests also have to be taken into account. Prosecutions of parents are generally not in their children’s interests.

29. Nor would families be policed by social services. The threshold for formal social service intervention in families would remain the same, namely “significant harm,” triggering an investigation under section 47 of the Children Act 1989. Physical punishment which did not reach this threshold might be followed up, as it is already, but would not lead to statutory interventions in family life. Numbers of children in care would be expected to remain the same and, in time, fall, as more children enjoyed a world free from physical violence by those who care for them.

September 2011

Written evidence submitted by Vanguard Consulting

INTRODUCTION TO VANGUARD AND THE VANGUARD METHOD

1. Vanguard helps service organisations change from a “command-and-control” design to a “systems” design. The Vanguard Method enables managers to study their organisation as a system and on the basis of the knowledge gained, re-design their services to improve performance and drive out costs. We have extensive experience of working with local authorities, the police and housing associations in the redesign of care services, and we were involved in the submission of evidence to the Munro review of child protection earlier this year. The authors of this report were Joanne Gibson (Vanguard’s specialist in social care interventions) and Brendan O’Donovan (Vanguard’s Head of Research).

EXECUTIVE SUMMARY

2. Having worked with many local authority children’s services departments, we have discovered that, together, the IT system and its concomitant performance management targets constitute an active barrier to good child protection work taking place. There is poor interaction between partner agencies. It is not uncommon to find social workers spending up to 80% of their time in front of their computers. This prevents them from spending the necessary time required to understand the true needs of the child/family they are working with. Cases thus re-present at a later date (up to levels of 70% repeat demand in one authority), often after further deterioration in circumstances. This high level of repeat demand misleads managers into believing that there

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18 Churches Network for Non-Violence http://www.churchesforon-violence.org/charter.html This sister organisation to Children Are Unbeatable! sets out the Christian arguments against physical punishment and seeks support from other faiths.


20 August 15 2011, see http://www.bbc.co.uk/news/uk-politics-14527540

21 See evidence by the Director of Public Prosecutions to the Joint Parliamentary Committee on Human Rights, May 25 2004. He sensibly did not rule out the possibility of prosecutions of parents for mild smacks but considered this would be very rare (an example might be when the victim is disabled or where the smacks are frequent or humiliating).
is just too much demand to be dealt with, thus justifying higher thresholds for care and support. However, if these repeat demands could be designed out of the system, significant capacity would be freed up to deal with cases properly first time. The current measures of success are unreliable: new, locally derived measures should instead be based around the measurement of a) how well social workers are understanding the problems they encounter, b) the timeliness of the intervention, and c) whether they were able to intervene and stabilise the situation “right first time” so that these cases did not re-present to the system at a later date. Experimentation has taken place around jointly improving the system with promising initial results, but these experiments require political support if they are to be successfully replicated elsewhere. Even though the government has publicly withdrawn from the imposition of central targets, managers in the system remain conditioned to create their own. These continue to get in the way of allowing the workers to do the right thing for children and their families. Instead, these systems need to be reconnected with their true purpose. The Vanguard Method has a track record of facilitating just such a reengagement of managers with their work, a necessary prerequisite to improving the child protection system in this country.

Does the child protection system allow for effective identification of, and provision of early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)?

3. Having studied the child protection system, we would not characterise the current design of the system as enabling effective identification of abuse and exploitation, and nor does it provide early help to children at risk. The whole system is not designed around the child, but instead around the cumbersome IT system (the Integrated Children’s System or ICS) and its accompanying standardised set of forms that tie the social workers into a rigid procedure. The IT system, in turn, is designed primarily to enable the capture and reporting of performance management data (which, in effect, constitute targets). We have learned that nearly all of this data is irrelevant and unhelpful: it is not used to aid learning and understanding about the system from the child/young person/family’s perspective.

4. The consequence of having a system that is designed around the requirements of the IT system is that the social workers spend between 60–80% of their time in front of a computer or filling in standardised forms (see White et al 2010) rather than understanding what matters to the child/young person. Because of this focus on meeting the requirements of the IT/performance management system, the workers all too frequently miss the real underlying cause of the problems facing the family/child. Often this lack of understanding continues for years: our research has shown that the same cases continue to re-present within the system. Studying historical data it was apparent that, from the families’ perspective, their needs are never really dealt with and their cases continue to bounce around the system for years.

5. We have found that managers in children’s social care have become concerned with “gate-keeping”: attempting to keep people out of the system because of a widely-held belief that there is too much demand to be dealt with using the scarce resources at their disposal. Paradoxically, our studies show that most of these cases are examples of repeat demand re-presenting to the system because it was not handled in the right way at the first point of contact. Understanding the nature of the demands that are predictably hitting local authorities’ child protection systems has taught us that a large proportion comes from cases that are already known about, but have not been dealt with properly. In one local authority, they found that up to 70% were cases where the child/family involved were already known to the system from previous contacts. Whilst this is a damning statistic, it also shows the potential for improvement if the preventable “failure demand” (Seddon 2003) can be removed. Regrettably, managers’ focus has been distracted from getting it right first time for the child or family. Instead, they concentrate on meeting timescales, hitting targets and trying to fit incoming demands to their list of services on offer. Unfortunately, these services are regularly inadequate for the needs of the family/child and do not address the underlying causes of the problem. For example, in one local authority they commissioned a voluntary sector organisation to provide support to the victims of domestic violence but did not provide any service to challenge and change the behaviour of the perpetrator. The consequence was many repeat demands of domestic violence often involving the same perpetrator.

6. There is minimal evidence of the voice of the child or young person being captured in the cases that we have examined. From a manager’s point of view, all demands within the system are to be treated in the same, undifferentiated way (characterised as “meet the targets at all costs”), when in fact studying the work shows each case to be unique and requiring a bespoke response. The consequence is a system that is inflexible and unable to take the necessary time to understand the real needs of the child or young person (failing the systems principle of “requisite variety”, as referenced in the Munro report). As a result, the system provides services that are not “fit for purpose” and are thus a poor use of public funds.

7. Our work has shown a lack of ownership from partner agencies within the system. The result is duplication and unnecessary repetition of information. Often partner organisations provide inaccurate information (explained in more detail below). This is a consequence of their own dysfunctional, performance managed
organisational systems (eg in the police or NHS) that bind them into collecting and providing information in a certain, narrow way. This inevitably results in re-work by other organisations. The experience for the child/young person and family is bewildering as they are frequently asked the same questions many times over, and they lose track of who to contact with their problems. Often they are seen by numerous workers and there is very little opportunity for the child/young person/family to build trusting relationships with workers and thus tell their full story.

8. Within the current system, there is little evidence of measures that help learning and improvement. The targets which currently drive children’s services managers do not relate to the real purpose of the system and certainly do not demonstrate the effectiveness of interventions in the lives of the child/young person and family over time. In our work with children’s services departments, we are supporting the workers to develop measures alongside the child/young person and family that will help all parties understand how well the help given is supporting the individual/family. There are also measures to help understand the timelines of the help/support from the child/young person/family’s perspective, as well as measures of whether the workers were able get it “right first time”. If a case is dealt with “right first time”, this stabilises the situation for the child/family and thus demonstrates both the efficiency and effectiveness of the system. In this way, a truly preventative system can be created where professionals are allowed to become re-engaged with their work.

9. In place of the current targets, there need to be new, locally derived measures. These measures, in our experience, have been both quantitative and qualitative and follow these principles:

- They help workers to understand and improve performance in their system.
- They are directly derived from the work (rather than being centrally specified).
- They demonstrate capability and variation over time.
- They are in the hands of the people who do the work so that they are able to control and improve their work.
- They are used by managers to act on and improve the system.

10. In order to work in this way, there needs to be a definite shift away from the prescriptive approach which has characterised the way central government and the regulators have previously acted. This is commented upon in more detail below.

11. Although the Munro review and the Government’s response acknowledges that better measures must be used, our learning and experience is that many managers and leaders do not know any alternative to management by targets and arbitrary timescales. They do not understand with clarity the purpose of the current system from the young person’s perspective, thus they do not know what good measures would look like to help them achieve their purpose. Furthermore, they do not know by what method to improve the system. The Vanguard Method allows for just such learning to take place.

What are the factors affecting the quality of decision-making in referral and assessment, and the variations across the country?

12. There are a number of factors affecting the quality of decision making and assessment. Many social workers now lack the basic skills required to build a trusting relationship with the child/young person and family. This is worsened by the fact that it can be a different social worker at every contact and the aforementioned problem that the social worker is more focused on filling in their performance reports.

13. Many social workers have become comfortable sitting behind a desk or at the end of the phone and are often in fear of using their own professional judgement in case it goes wrong and they get the blame. The consequence is that social workers often retreat from difficult decisions and there can be huge variation in the assessment of needs and then the provision of help to meet the needs.

14. From our time spent in the work with frontline staff there is perception that they are lacking managerial support. Managers have become focused on “strategy” and are actively encouraged by their seniors not to get involved in operational day to day cases. In one local authority which has just restructured its service, the managers have been explicitly told not to get involved in cases. In other words, decisions about care and support are made by people who do not meet the child and thus do not understand their underlying problems. The obvious danger of working in this way is that arbitrary and confusing decisions are made about the services provided to a child without an understanding of what the impact will be on that young person. Instead, managers need to become strong leaders spending time in the work: handling cases, asking the right questions, using the right measures to learn and improve, acting on the system, removing obstacles in the work and enabling and supporting their staff. We would pinpoint this degree of managerial connection with the frontline as the biggest source of variation in the quality of decision making across the country. If these disconnected managers are not given a framework and method of re-education then there will be no sustainable improvement in the child protection service.

15. To have such leaders in the work, connected at all times to what is going on at the frontline, would create an environment of trust and support. This in turn would enable more effective decision making, based on doing what matters to the child/young person and family whilst ensuring their safety.
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What are the appropriate thresholds for intervention, including arguments for and against removing children from their families?

16. We are aware of the ongoing discussions around the pros and cons of removing children from their families. Sadly, from our work in the family court systems it is clear that there are a number of families where it is predictable that the children will have to be removed from the family home. However, these cases may have been preventable if they are dealt with before the situation is allowed to deteriorate. Many could have been prevented if early intervention work had taken place, with the emphasis/resources placed on understanding the underlying causes of the problems and then providing the right support at the right time for the child/young person/family. Talk of “thresholds” for intervention, in our view, may lead us to miss the point: whether to intervene or not should be a decision taken by the professionals who have had the appropriate time to understand the particular context for the child/young person.

17. It is our belief that if social workers were released from the bureaucracy and irrelevant data collection activities, and they were instead enabled and supported to focus on doing what matters as defined by the child/family, fewer cases would end up in the legal system. This is a view validated by the judiciary we have talked to as part of work with the Munro review. Indeed, the work taking place in the Inner London Family court as part of the Family Drug and Alcohol court is a demonstration of how different the system could be.

Do the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child?

18. Vanguard has spent a considerable amount of time in the child protection system end-to-end. This includes work understanding the systems which govern those organisations that closely interact with the child protection system. These include health, police, housing, adult social care, education and the voluntary sector. Child protection appears to be less of a direct priority for these organisations, all of whom are driven by their own performance management systems, which prevents them from understanding the purpose of the child protection system from the child’s perspective. This focus is in turn driven by the regulation, funding and other “system conditions” that govern their world. As an example, in one local authority 36% of referrals came into the child protection system from the police. Of these almost 100% were, in systems terms, “dirty” ie missing key information which resulted in the social worker having to undertake further investigative work in order to get the information to carry out the initial assessment. When we worked with the police to understand the reasons for this, it became evident that they are under pressure to meet their own service targets and complete their own forms and paperwork. The consequence is that child protection referrals in written form are rushed and often inappropriate. In working with the police and social care in the potential redesign of the child protection system, the most appropriate design is to have these individuals working alongside each other in the local community. In this way, they are able to jointly build up their knowledge and information about the local children and families in order to allow early intervention. Sadly the perceived procedural and structural hurdles preventing widespread adoption of this system have often been too much for the local managers to overcome and so the redesign has faltered. This is very regrettable. Government needs to enable this type of multi-agency local experimentation if it is serious about improving the system for the better.

19. We believe that the roles of Government and, in particular, the regulator must significantly change if we are to have a skilled, competent and safe child protection service. As already noted, the social care system and the family court system is currently overburdened with targets and unnecessary controls that prevent the people who do the value work with the families concerned from actually doing what matters. The regulators will need to ask the right questions of the people who work in this system, questions which relate to helping learning and understanding. Inspection of performance should be concerned with asking only one question of public sector managers: “What measures are you using to help you understand and improve the work?”

20. The choice of measures is then a matter for the manager responsible, and the requirements are that they are used to both understand and improve the work. The only reliable way for the regulator to inspect will be to turn up where the work is done and ask about measures-in-use. This would show what is being learned from measurement, making assessment more reliable and increasing all parties’ focus on the validity of measurement—are we measuring the right things? The efforts of the centre should be focused on understanding what works and providing information about method, leaving managers free to decide what particular method(s) might suit their particular circumstances. It is to put control where it needs to be if the child protection system (and the public sector more widely) is to improve.

October 2011
Written evidence submitted by 28 TOO MANY

1. From my experience of working as a psychologist and Capacity Builder in aid work since 2001 and in anti female genital circumcision (FGM) since 2005, I believe there is insufficient care offered to women and girls at risk of FGM in UK.

2. NHS and social services do not seem in good liaison and the BMA and doctors often do not know what to do with concern cases.

3. There was a large number of concerned calls from teachers and nurses approaching charity services this summer, at the beginning of the Cutting season.

4. Too often, agencies are over sensitive to issues seen as cultural at the cost of the rights of girls too young to give their consent to practices such as FGM.

5. More representation is needed from faith and cultural experts to guide policy and legislative change. I am happy to offer free advice as required.

October 2011

Written evidence submitted by the Royal Borough of Kensington and Chelsea

Executive Summary

This submission provides evidence about the way our relationship based social work delivery model functions to achieve better outcomes for children in the Royal Borough of Kensington and Chelsea. The system is underpinned by a commitment to informed decision making, critical reflection of social work practice, high standards of case recording and performance management.

In Family Services there are three important support functions that operate alongside social work teams: Family Child Protection and Support Advisers who provide child protection expertise in all the stages of the child protection process, including chairing planning meetings. A Family Assessment Support Team to coordinate and undertake multi-agency expert parenting assessments at the highest threshold for child protection intervention. A Health Link Team to identify child protection concerns at pre-birth or birth and co-ordinate and provide multi-agency support to mothers.

We put forward evidence which suggests that the relationship based social work delivery model is effective for engaging with parents who otherwise would be resistant to accepting support services. The specialist teams and strong partnership working with families are essential to achieve high quality assessments. The high standards of practice and easy access to child protection expertise demonstrate an evidence led approach to setting child protection objectives in child protection planning. The critical appraisal of decision making processes is built into the system to ensure that children are not separated from their parents unless there is robust evidence that not doing so would result in likely or actual significant harm.

A final important point is that empowering social workers to make professional judgments in decision making processes is possible when there is a whole system approach to ensuring high standards of practice. The system is underpinned by respect for professional judgment and a strong commitment to providing frontline management support and career development opportunities to help staff progress into advanced practitioner and management roles.

1. Introduction

1.1 There are an estimated 29,000 children and young people aged 0 to 17 resident in the Royal Borough of Kensington and Chelsea, and around 170,000 residents overall. There were 3,069 children in need episodes in 2009–10, and the care population is well below the London and England average. The most prevalent reason for a child being in need of social care services was “abuse and neglect”. In total, 192 children in Kensington and Chelsea required a Child Protection Plan during 2009–10. This is 64 child protection plans per 10,000 of population, similar to England (63) and below London levels (75).

1.2 The Royal Borough of Kensington and Chelsea enjoys a positive history of strong partnership working under the Local Safeguarding Children’s Board (LSCB). The LSCB advisory groups comprise representatives from a wide range of local organisations and bodies including service users and voluntary sector organisations. Over 300 staff received LSCB training in the last year, and there is a strong commitment to continued professional development amongst senior staff.

1.3 In 2007, the Joint Area Review concluded that the overall contribution of Family and Children’s Services to keeping children and young people safe was outstanding. Since then inspections have consistently confirmed that the Council’s children’s services maintain high standards of performance, and references to more recent inspection findings will be made as part of this submission.

1.4 The information collected for this response is organised under the following four main themes:
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(1) the effectiveness of the child protection system to safeguard children in Kensington and Chelsea;
(2) quality of practice and decision making in child protection cases;
(3) leadership, management and partnership working to safeguard children; and
(4) key challenges in the Child Protection system.

Information from the above themes is intended to respond to the point about whether child protection policies and practices assist professionals to work together in the interests of the child.

2. The effectiveness of the Child Protection System to safeguard children in Kensington and Chelsea

2.1 Children’s social care services are organised under Family Services within the Family and Children’s Services Directorate. There are six locality teams and two specialist teams within the Complex Health Needs and Disabilities service group: Children with Disabilities team and the Health Link Team. The locality social work team structure is “patch based” and covers small geographical areas across the Borough. There are many advantages to this social work delivery model: reduced bureaucracy; continuity in support to the child and family; professional autonomy and improved retention of social workers and managers; effective inter-agency working at grass roots level; and easy access to services for families.

2.2 Ofsted inspectors recently commented that:

“Duty arrangements are effective and ensure a timely and appropriate response to concerns about children and young people”.

The duty system is different to most other local authorities as enquiries and referrals are contained within locality social work teams rather than a central function or a dedicated duty team. This gives managers the flexibility to create duty structures which builds on the strengths of social work staff in the team.

2.3 Duty arrangements reflect the skills, experience and preference of social workers in the team. Less experienced social workers tend to work as back up for a period of time in order to build up experience in the role before taking on a main duty role. Some teams run a formal pairing system with the same two workers taking on duty, and covering for each others’ case work. The duty system is subject to regular audits to ensure consistency in the application of thresholds across the social work teams.

2.4 Social workers report that they are empowered to make professional judgment around thresholds which enables them to work preventatively rather than defensively in referral and assessment work. It demonstrates respect for professional judgment and makes social workers feel that they can make a valued contribution to decision making processes.

2.5 It is common that social workers are allocated a case that they have assessed at the initial referral stage, which helps them develop expertise in new areas. This is possible because there are no artificial boundaries between referral, assessment and long-term support. It helps create a sense of job satisfaction as social workers can follow a case from the most critical point and then stay involved and experience the progress that is made as the family is helped by the service.

2.6 The Children with Disability team operates their own duty system with staff specifically trained to assess child protection needs for disabled children. This provides a seamless service and allows social workers to build strong and lasting relationships with families where children are subject to child protection concerns.

2.7 The Borough has won a Government e-award for its own version of the Integrated Children’s System. It was designed to aid professional judgment and help analyse information about a case rather than create unnecessary bureaucracy that take social workers away from spending time with families. The high standards of recording and easy overview of a child’s case records have consistently been praised by Ofsted in inspection reports.

2.8 A recent unannounced inspection highlighted the capacity to respond to child protection concerns effectively:

“Child protection investigations are undertaken promptly and thoroughly and appropriate steps are taken to ensure children’s safety”.

The effective links between locality social work teams and early intervention services, schools and community health services can be attributed to the small size of the geographical area in which the same professionals operate alongside each other for long periods of time.

2.9 The child protection system is supported by the effective partnership working between frontline social work practitioners in Community Mental health services. Social workers often work alongside adult mental health workers in child protection cases where there are parental mental health concerns. It improves the quality of assessments and the outcome for the child as the parent is supported alongside statutory interventions.

2.10 Child and Adolescent Mental Health Services (CAMHS) provide an outreach service to schools within an early intervention service that provide priority access to locality teams. There is evidence to show that this
approach has contributed to identifying and addressing domestic violence and other ‘hidden’ family problems that has had an impact on the child’s safety, behaviour and emotional well being in schools and at home.

3. Quality of practice and decision making in Child Protection Cases

3.1 The quality of practice in Family Services has consistently been praised by inspectors, and the strong commitment to training and professional development is reflected in the Local Safeguarding Children’s Board inter-agency child protection training programme. The strong offer of reflective supervision by highly skilled and experienced senior staff is a further important aspect of ensuring social workers are supported in the child protection system.

3.2 The social work culture of critical reflection is evident in consultations and professional network meetings to review child protection plans and progress. When a child has remained on a child protection plan for longer than expected, a critical review is undertaken to bring a new perspective to the case and explore other options to achieve child protection objectives. There is also the option to bring in a second worker to share the assessment process and reflect on practice as the case progresses. There is a strong commitment to undertaking regular comprehensive audits of individual cases, and findings are discussed with social workers in supervision to identify areas of good practice and for improvement.

3.3 A major strength of the decision making process is that the same social worker and team manager are involved in the various decision stages of a child protection case (referral, assessment, long-term support and statutory care process). Oversight is provided by the same Head of Service, which provides an additional layer of consistency in decision making processes. The continuity of staff is a further safety mechanism as families can rely on decisions being based on an understanding of the history of the case and the presenting issues.

3.4 A Strengthening Families Child Protection Conference model is currently piloted to support the child and the family to actively participate in the child protection conference. During the conference process, children are offered independent advocacy support to give them a stronger voice in child protection decision making processes. A range of creative approaches are explored with the child to find ways of helping the child to make a meaningful contribution to the child protection conference. A key aspect of the model is that parents are helped to generate solutions to set child protection objectives that will improve the outcomes for the child and help achieve family stability.

4. Leadership, management and partnership working to safeguard children

4.1 In the last unannounced inspection of frontline services, Ofsted commented that knowledgeable, confident and accessible managers support staff well. The management team is seen as providing clear overview and direction in child protection cases, which helps contain caseloads at manageable levels. They are seen as approachable and available, and attend visits with social workers when required eg decisions to initiate care proceedings.

4.2 Local Safeguarding Children’s Board (LSCB) partnership working is effectively embedded in frontline practice which is demonstrated by social workers, health and adult professionals working alongside each other in child protection cases. Parenting practitioners from a broad range of disciplines jointly deliver parenting support to parents who are subject to child protection or family support plans.

4.3 Staff have access to training and staff development to improve practice and achieve greater levels of responsibility, which help develop senior practitioners and managers from within the service. It also helps retain social workers as there are career progression opportunities within the system, and some move on to advance their careers in other Boroughs.

4.4 Team managers have access to detailed, good quality performance management information to identify areas for improvement at an early stage and take timely steps to address these. There are regular performance workshops with staff at all levels to maintain high standards of practice and deliver strategic improvement objectives.

4.5 Finally, strategic business planning structures such as service improvement plans for social work teams and professional development plans are key to maintaining a high quality child protection service. It focuses social work services to achieve strategic business priorities which take into account new policies and statutory guidance, findings from audits and performance management processes and practice development objectives.

5. Key challenges in the child protection system

5.1 There are a number of issues that present challenges for frontline practitioners within existing child protection policies and systems. It is commonly accepted that it is harder to assess referrals and manage consistency in the application of thresholds at the levels immediately below child protection interventions. Factors such as work load pressure, variable experience across a team, inconsistent thresholds in referrals from early intervention services all contribute to difficulties in assessing cases. Team managers encourage social workers to reference the threshold document adopted by LSCB, which has proved effective in empowering them to make professional judgments.
5.2 There are specific challenges in identifying, assessing and evidencing child protection concerns for children with disabilities given the communication needs of this group of children. There is also the risk of over-familiarity with a case given the long-term nature of these cases. By containing the duty and referral function within the Children with Disabilities team, it is possible to apply thresholds criteria that take into account child protection concerns that impact differently on this group of children. At the same time, it is felt that children with disabilities are in need of an independent advocate who can support them to have their views communicated in child protection processes.

5.3 The high threshold for parents with mild learning difficulties to access adult social care support contributes to children experiencing neglect. These parents need long-term support to ensure the well-being of children, and there is a role for family support workers and adult support services to address adult learning difficulties that impact on their parenting capacity.

5.4 There is the requirement for an IT system to capture multi-agency referral and record assessments in cases that do not reach statutory thresholds for intervention (eg Merlin police reports, Common Assessments). There are developments under way but there are specific issues to take into account to enable tracking of a child’s journey from early help to statutory services.

6. Recommendations

6.1 The evidence of the functioning of the child protection system in The Royal Borough of Kensington and Chelsea is intended to inform the Child Protection Inquiry, and there are four main recommendations that we wish to put forward.

6.2 We propose that the Committee considers making the following recommendations:

(1) that the relationship based child protection model operated in the Royal Borough should be replicated in other local authorities to ensure the safety and welfare of children in need;

(2) that social workers are empowered to make professional judgments in decision making processes, supported by clear threshold criteria and frontline management support;

(3) that there is a whole system approach to performance management which engages frontline practitioners and staff at all levels of the child protection system; and

(4) to integrate reflective supervision, training and professional development into their professional work in order to build confident staff and thereby retain social workers and managers.

October 2011

Annex submitted by the Royal Borough of Kensington and Chelsea

CASE EXAMPLES

Only general case details have been included to protect the confidentiality of the families that feature in the four case examples that are submitted as supplementary material. All families have been subject to child protection procedures in this Borough, and the information has been provided by frontline social work practitioners.

THE P CASE

The health link team was consulted by the Community Midwife team about a pregnant mother who caused concerns because of a psychiatric condition. A Child in Need support plan provided seamless support from the professional network. Following the child’s birth, the case progressed to the child protection system as there was deterioration in the mother’s mental health. The police became involved because of domestic violence concerns, and the mother was placed in supported accommodation.

The Health Link team manager participated in the Child Protection Conference, and later chaired the Core Group meeting. This helped ensure that the professional network worked alongside each other, and adult mental health support was required to engage her in support services.

Significantly, the same case holding social worker stayed involved and the same adult community mental health team remained involved despite changes in the address when the mother moved into supportive accommodation, and later re-housed in another area in the Borough. The partnership with the Police was particularly effective for addressing domestic violence concerns and threats against the mother as a result of a family feud. The family was provided with secure and safe accommodation as a result of effective collaboration with partner agencies.

The value of the Health Link team was demonstrated by the strong relationship the social worker had developed with the mother at the pre-birth stage. The team manager provided a continued oversight of the case by chairing the child protection core group meetings. As the case progressed to the child protection system, the same professionals remained involved which secured continued engagement with the mother in achieving child protection planning objectives.
The case was particularly challenging as the mother attempted to split professionals. The ability of workers to hold on to the case, despite changes in the address, was critical to the successful outcome of the case.

The outcome for the child was that the mother was persuaded to accept health visitor and parenting support; both of which provided a safety net and greatly aided the child’s development. This was a major challenge given the complexity of the mother’s psychiatric condition, and could not have been achieved without a long-term comprehensive support plan and collaborative working between Family and Children’s services, Health services and Adult Mental health services.

THE E CASE

The case was referred to the Family Assessment Team (FAST) because the child, aged five years, had been subject to a child protection plan under the category of neglect for longer than expected. At the time of the referral the main concern was that the child had witnessed domestic violence, and that this was harmful to her. The concern was heightened by the mother’s binge drinking of alcohol, and the emotional impact on her child. The mother was willing to accept help to address the problem but had remained defensive and avoidant in her contact with the social worker.

The FAST assessment took place over a period of three months. A senior social worker took the lead and co-ordinated assessments by a substance misuse social worker, family support worker and a clinical psychologist. Each professional was responsible for assessing a particular area of concern. The psychologist assessed the child’s needs and the impact on the child of domestic violence and the mother’s emotional needs; the family support worker assessed the mother’s parenting skills; the substance misuse worker assessed the mother’s alcohol use; and the social worker the mother’s capacity for change and ability to work with professionals to address her problems.

The information was then assimilated into a parenting assessment, which found that the mother had a history of abuse in her own childhood which explained the reason for being resistant to engage with the social worker and withdrawing from support. She had a long-standing history of problem alcohol use, and recognised that she needed to accept help with her binge drinking. The parenting and day-to-day care of the child was of a high standard and the child was provided with attuned and sensitive care. It was also assessed that the mother had good insight into her problems and was highly motivated to make the changes required to provide stable parenting for her child. The child was developing normally but with some signs of anxiety, and was receiving play therapy by CAMHS supported by the mother.

The findings of the assessment helped the professional network gain a better understanding of the impact on the child of the child protection concerns, and helped engage the mother and child in essential support services. As a result there was renewed confidence that the child protection plan would be effective, and it was decided not to instigate child care proceedings.

The value of the quality of practice and expertise was demonstrated by the multi-disciplinary approach bringing together particular dimensions to provide a holistic view of both the child’s and the mother’s individual needs and how they could be best supported for the child to remain in the family.

The outcome for the child is that she is no longer subject to a child protection plan, and the mother has engaged well with services in the last five months.

THE G CASE

The case was referred to the family intervention worker to provide outreach family support as the children were provided with a child protection plan under the category of neglect. The family had a long history of social work involvement, and the mother who has moderate learning difficulties was known to be resistant to accepting social work support. The mother had been resistant to accepting support and the role of the worker was to build bridges between the family and the social worker, and provide individual support to the mother to implement the child protection plan.

Given the mother’s learning needs, it initially took gentle persistence to engage her in the issues that had caused concerns about neglect. The worker visited weekly and extended the sessions to repeat and explain things in different ways to help the mother gain an understanding about the needs of the children, aged 13 and 16.

The mother responded well to making improvements to the home environment which was in an unsatisfactory state. The children were sleeping on mattresses as there were no beds, the family could not sit down together as chairs were missing and the walls were dirty and marked. The worker engaged the boys in painting their bedrooms in colours chosen by them. An application was made to a charity for purchasing carpets, and furniture for the bedrooms and living room were provided for free by another charity.

The worker also helped link up the children with an adolescent outreach worker as they were out of education due to bullying incidents and threats of violence. The oldest child is now attending a local College, and the younger child has started secondary school in the Borough.
The mother is now open to accessing support services in the community but continues to need support from the family intervention worker to manage bills and complete paper work as she struggles to read and write. Because she has mild learning needs she does not qualify for adult social care support but without ongoing support the family would be severely affected by the mother’s learning needs.

**THE N CASE**

The case was referred to the locality social work team because of child protection concerns about the child, now aged 14. A child protection conference was convened and a child protection plan was agreed on the grounds of physical abuse. The plan included holding a Family Group Conference which helped mobilise the extended family and secure the mother’s co-operation to implement the child protection plan. The Adolescents Service provided out-reach support to the family and engaged the child in direct work. The school and health services were closely involved throughout the child protection planning process.

The role of the social worker was to work with the mother to address issues from her own childhood and culture where physical chastisement was an accepted form of disciplining a child. By providing parenting support the social worker was able to help the mother understand that changes were necessary to ensure the safety and well-being of the child.

The case has now been closed since the mother was able to demonstrate that she had developed parenting skills that equipped her to provide safe care and respond better to the needs of the child A further safety mechanism was that the extended family continued to provide support to the family.

**October 2011**

Written evidence submitted by Florence Bellone

Step by step I was admitted inside family groups and could collect parents witnessing, see their evidence and court paperwork. Their psychiatric expertise picking up every little neurosis, life traumatism and element of personality to call them “mental health troubles”; their social workers reports with incoherent series of allegations, fake evidence and lies: the repressive and arbitrary style of every piece of paper deemed “confidential”; the denunciations, the anonymity of denunciators and experts as well, all this looked as a repetition of Vichy France, Nazi Germany, Stalin Russia or any totalitarian regime catalogue of repression tools. The amount of suffering and humiliation inflicted on innocent families “In the Best Interest of the Child” made me think of women tortured in Middle East “in the name of Allah”.

In January 2010, ironically, the leaders of the three big political parties produced in Parliament public apologies for the 70 years of Migrant Children programme. Only one thing changed from the end of that programme: the children are staying in the UK. They are adopted, in foster care or in children home.

To get a more complete insight into the system, I learnt how to be a basic McKenzie Friend. I say a basic one because this denomination includes from the profane knowing the law and asking right for audience to the supporter whispering advice to the parents in court and not able to challenge illegibilities by the book. When legal aid is not available anymore for them, many parents become litigants in person but they are not enough experienced MKFs available for all of them. Hearings with parents allowed me to see how judges dealt with them. Also I could attend hours of assessments and pre-birth assessments of parents by social workers and other professionals involved in the process.

1. **HOW SOCIAL SERVICES GET INVOLVED WITH A FAMILY?**

(a) **DENUNCIATIONS.** Social services call them referrals. For example, you call them to report noisy neighbours and say that they have a messy house and dirty kids. Quickly social workers would ring the bell of the designated home and after a few visits during which they open cupboards and tick cases on a stapled load of paper, the children would disappear (often a Friday afternoon) but nobody will know why and on which base the mess in the house became such a huge crime. If the social workers come just before the weekly shopping and open an almost empty refrigerator, they have a point and write that the family is starving the children. Schools in some area are like family police stations with a named teacher in charge of denunciating.

(b) **ASKING SOCIAL SERVICES FOR HELP.** This is the major trap in which the humblest families are regularly falling. Families used to live in dependency of the state are literally social workers preys. They would call social services for solving some education or material problem. Its is often by the social workers appreciation that normal people have been deemed disabled and finally convinced of being disabled or of having mental health issues keeping them of working. The best example is “learning difficulties”; a major pretext for having neither work nor the right of keeping children. These parents could do any job which is not requiring intellectual skills and none of them switch on the gas cooker to get water. Most of the time they only lack education. And uneducated people are perfectly able to raise their kids and are often more concentrated on them than wealthy professionals.

(c) **ASKING HELP BECAUSE OF DOMESTIC VIOLENCE.** Many moms lost their children after leaving a violent partner. They are told that even if they separated, there is a doubt on the emotional link which could
push them to come back to the abuser. By precaution the children for who they asked help are also removed from her.

(d) ACCIDENT OR ILLNESS. I believe that the baby illnesses or children accidents are the reason for which more and more middle-class and educated people fall in social services nets. A baby with brittle bones disease, for example, can happen in any social environment. By bringing your baby or child to A&E, you take the risk of being deemed a criminal. Creating a climate of fear related to the hospital will not solve cases of criminality toward children. It is just pushing the real criminals to hide their game better. No society can be healthy in these conditions. The number of parents who lost a baby to social services because of this means that because we don’t understand fully some illnesses, we make the families the new witches. Also children are accidents makers, only hypocrites would deny it. Parents know that they will be concerned for many years about a possible accident costing injuries or death to their children. But they can’t also worry about being accused of hurting them if that happens. If you want every parent to sign for a zero tolerance regarding their children accidents and health problems, let stop having children. Children cannot be a police tool to control citizens! One thing is showing how dishonest the referral system to social services by doctors and hospitals is: most of the parents accused will not be prosecuted as police doesn’t prosecute without evidence. However social services will remove the children on the base of unproved allegations. The punishment happens for “in case you would be a criminal”. As the removal of babies at birth happens because “you might not be able to be a good mother”. The family courts are a tribunal of speculation, not facts.

(e) HAVING BEING REMOVED FROM YOUR OWN PARENTS, ADOPTED OR RAISED INTO CARE. It is as having a tattoo indicating “property of the state”. When you get pregnant, you are treated as a recidivist. The files get you from birth. Very often, the reason to take your baby is imputed to the trauma of living into care or having being abused as a child! Very often the abuse happened into care or didn’t happen at all but the birth parents files say “abusers”.

2. BABIES REMOVED AT BIRTH AND PRE-BIRTH ASSESSMENTS

This is an atrocity. No other European country does this. It is a crime against humanity and despite being a quite strong and privileged person, it caused me more bad nights that the thought of poverty and famine. Keeping a baby of the health benefits of being breastfed is also a crime. I have seen in a maternity a mom feeding and cuddling her son before a complete stranger would snatch him from his cot. But in some maternities the new moms are locked in an isolated room sometimes guarded by a policeman. In some hospitals the social workers trawl for babies as vultures and take several in the same week. During pre-birth assessments, social workers who don’t like the father would blackmail the mother to separate. They would also blackmail the grandparents trying to get the residency of the baby to keep him or her from vanishing through the adoption market. Then they put as a condition for residency that they will cut the ties with the parents, so their own children. The choice is “your grand-child or your children”. Social workers have a special taste for destroying couples and families.

Women prohibited of being mothers are said to pose a “risk of future emotional harm” to their children, and often deemed “emotionally unstable”. As far as I am concerned emotional stability happens only after brain death. And for exposing a child to emotional harm, this is the only way of keeping him or her alive. Life is bringing emotional harm and if it was only through the family, it won’t be much harm. Cafcass and social workers think that they are better than nature and that the harm caused by their brutal control will do a better adult than the birth parents emotions. But if later the child becomes an 18 years old pregnant lady, still half-child and already half-adult, she will be treated as an adult and will have her baby removed. This has triggered many suicides of young ladies. Remember the “British Fritzl” daughters who endured years of abuse rather than reporting him, because the social workers would remove their children. Even born from incest and abuse those children had at least loving mothers.

3. USE OF PSYCHIATRY

This is the oldest technique of repression in modern world and the only one allowing the elimination of individuals who did nothing to be jailed. I met parents who have been sectioned and honestly, if we follow the standard of mental health used by social services, we should section the totality of Latin countries where many of the syndromes used to catalogue parents are even not recognised. The Muchausen by Proxy syndrome is among the funniest. It is when you bring your child to the doctor to attract attention on yourself. It is one of the major causes of children removal. In my view the experts making this diagnosis are dangerous psychopaths. Psychiatry is not an exact science but it is still supposed to be from the medical sector, not the police one.

Every aspect of the personality can become a “personality disorder” when it comes to remove a child. But which personality disorder leads people to work in such a disgusting business as framing families, violating human rights and manipulating children life? I would quote an amazing letter of referral to social services received by one family: the grand-mother got angry in the hospital because of poor care given to her grand-son. The letter said that her grand-daughter was also present and because she saw her grand-mother angry, social services had serious concerns about her emotional future! I understand the importance that the Anglo-Saxon society sees in being self-controlled and I understand that some other countries are famous for showing rudeness. But obviously self-control is used for making the people behave like sheep, not for making them balanced and happy. I have seen parents deemed “rebel” as a negative point and social services would always
ask the parents “to work” with the “professionals”! A mother fled to France to give birth. The police had known that she was not a missing person and so closed the case. The social workers were so pissed-off to have missed her baby that they sent a threatening letter through their solicitor to her family. It is written that she had being verbally abusive in the social services office and hit a window so strongly that she broke it. I show the letter to a French social worker who is helping her starting a new life, so that she would understand that I was not exaggerating anything. She said: “I would have blown up their office if they would want to take my baby.”

4. Forced Adoption and Gagging Order

Forced adoption is against Human Rights, nature and common sense, and remind me in its many aspects about slavery and all kind of people “owning” other people. It is prohibited in all Europe and should be abolished without exception because it is virtually impossible to make sure that it won’t be any mistake or derive, as for death penalty. Social workers abuses exist everywhere but with forced adoption outlawed, the miscarriage of justice is not definitive, it can be fought. With no gagging order, the press can expose and the citizens react. You would never believe how many people told me that I was surely wrong when I said that British children could be adopted against the wishes of their parents. Even some of my British friends didn’t believe it. I’m convinced that the purpose of the gagging order is to avoid publicity for something which would disgust the people and to make sure that the international community doesn’t suspect what is going on. It would be possible to advertise: “you will loose your children if you are not conforming to the type of parent we want you to be”. Most of the punishments for more most of the crimes are known and the state wants the people to know them, from fines to life sentence. Most families are not aware than social services can destroy family life quicker than any genetic illness before it happen to them. The gagging order is supposed to protect the privacy and anonymity of minors. But children from 11 explained me that they have been prohibited of going to court despite asking for telling the judge that they didn’t wish to be separated from their families. They told me that the gagging order was only made to do this in all impunity. The gagging order also make evidence related to Child Protection a breach of law in itself. Several adults told me how they fled their adoptive parents and found back their birth parents and the truth on what had been done to them. One explained me how the police made him sign declarations against his mother by telling him that he was certifying that he had a meal.

Numerous foreign children have also been removed, mainly from Africa and Eastern Europe, but also from Western Europe. Because there is no warning regarding the removal of children in the UK, foreigners are taken completely by surprise. Parents have even been deported and children kept in the UK.

5. Family Courts

The family court does expeditionary justice. Particularly in County courts the judge believes the social worker and refuses to consider hard evidence brought by parents. The child is legally represented by a Cafcass guardian who in many occasions, didn’t meet him or her. The parents have no right to bring witnesses but the social workers can bring as many witnesses and experts from their “corporation” that they want. The social workers present a list of solicitors agreed by the Local Authority to the parents. They work against the parents behind their backs, enjoying the lack of legal knowledge of their victims. I have several judgements showing the building of fake evidence at a ridiculous level without even any care for making this fake evidence looking true. It is brutal to say this but social workers perjury, administration cover-up and mock trials are dominating family courts. No wonder why they don’t want the press to see this. In COA I have seen a judge who is now in the House of Lords justifying to a father the removal of his son that way: “You show that you could probably be a good father but you will raise your son in the dislike of the professionals (social workers) involved in your life.” In a County Court I have seen the solicitor of the LA short of arguments and pleading the Human Right of the adoptive parents who didn’t even know the baby. “They had been shown pictures of him and they would be distraught if told that the birth mother was opposing the adoption.” The judge acknowledged possible failures in the adoption process but said that he just wanted the baby adopted quickly for “his best interest”. The adoptive parents are also lied to and kept of knowing the truth.

6. Parental Units and People Involved in Child Protection

The parental unit or residential unit is a mini gulag where parents live under CCTV's even when going to the toilet. They are observed as mice developing illness in Huntingdon laboratory. Couples split under the pressure of the prison style life. As for prisoners and guardians, favouritism is putting some families under more pressure than others. Visits from relatives are restricted and friends visits are prohibited. They can’t go out or not alone. At the issue of this humiliating process, social workers think they know if those parents are OK or not to keep their children. This concept alone is a multiple violation of the Human Right chart.

The same kind of people accepts the same kind of tasks in similar circumstances in any country. Giving people the power of wrecking lives by their own judgement leads to torture spirit and police state. Many social workers and Cafcass guardians show signs of being repressed, frustrated, sadistic and enjoying a high level of voyeurism. Some only show signs of fearing loosing their job. When a social worker is not like this and dares writing a positive report on a family, the parents don’t see him or her again. A mainstream social worker is getting the case. The social workers are ordering the police, not the contrary. Very often, the police don’t like
them but can’t afford to not obey them. Hundreds of British families have fled abroad but the British police is never as zealous as the social workers about it, sometimes advising the families to never come back. More policemen had lost children to social services than social workers have been arrested by police.

**IN THE BEST INTEREST OF THE IDEOLOGY**

The biggest debate running about Forced adoption is: Money or ideology?

The costs of bringing some help to parents in difficulty would be nothing in comparison with the costs of assessments and proceedings. But many people earn money of this children traffic, from the foster families to the courts. One historian told me that “money was only the lubricant of the ideology”. The fight to avoid infanticides didn’t find any answer in the actual Child Protection system.

October 2011

**Written evidence submitted by Child Welfare and Research Unit, Lancaster University**

1.0 **Summary**

This evidence is submitted by Dr Karen Broadhurst, Ms Claire Mason and Professor Corinne May-Chahal on behalf of the *Child Welfare Research Unit* (CWRU) at Lancaster University. Members of CWRU are well placed to respond to this call for evidence as they are engaged in a sustained programme of research that addresses all four questions posed by the Commons Select Committee inquiry into the Child Protection System in England. Members of CWRU have led debates in regard to the latent conditions for error in children’s services, have refined methods for analysis of re-referral data, have identified strengths and weakness in local authority co-ordination of early help and have pioneered new online methods to facilitate children and young people’s own capacity to detect online predators. We are able to offer far more detail than this written submission conveys and therefore would welcome an opportunity to present oral evidence.

Key findings from CWRU research:

- Patterns of referral to the local authority (LA) and the LA response indicate entrenched problems of over-reporting/low rates of substantiation and at the same time under-reporting of actual harm and injury, that have characterised the child protection system in England for at least the past three decades.
- Re-referral data provides useful performance information for the LA but there is a need to differentiate the cases of children slipping through the net, indicated by a “multiple re-referral” pattern.
- An examination of cases with a multiple re-referral history found escalation of risk in every case. The most common reason for non-action on the part of the LA was that the case was open to another agency (eg universal services). This indicates systemic weaknesses in inter-agency working.
- Agencies of health, welfare, education and criminal justice demonstrated variable commitment to the Common Assessment Framework (CAF) and the Team Around the Child (TAC) process.
- There are clear boundary tensions between LA, universal services and community services around complex level 3 family support work, where there can be significant neglect issues.
- Agencies of health, welfare, education and criminal justice continue to manifest problems of differentiating risk in cases of domestic violence.
- Arguments for and against the removal of children cannot be based on child/parent characteristics/risks alone. Diversion of “edge of care” cases can be achieved on the basis of skilled pre-proceedings work, that provides a package of support/rehabilitation tailored to the needs of children and families.
- New risks to children, arising as a consequence of new media require a different approach to the identification of risk.

2.0 Qu: **Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)**

2.1 Research with a number of LAs indicates that LAs continue to be swamped with a high volume of referrals, many inappropriate and many unsubstantiated. This indicates a little change in problems that have come to characterise the child protection system in, at least, the last three decades.

2.2 Referrals to the LA continue to be made by, predominantly, professionals. The LA remains the key gateway for help in this context. The organisation of LA response—particularly in regard to the call centre methodology—does not constitute a system that appears to facilitate self-referral from children, young people and families.

2.3 Our work with a number of LAs has found that both team managers and more senior personnel monitor re-referrals rates and take steps to analyse the causes for these. But in our research work, we identified the
importance of detecting cases with a “multiple re-referral” pattern, from the bulk of re-referrals. We defined cases of “multiple re-referral” as those where there were 10+ re-referrals, with a re-referral pattern extending beyond 12 months. Profiling of these cases clearly indicated that a percentage of children and their families were “slipping through the net” of preventative services and that those cases were concentrated in teams with clear staffing deficits.

2.4 We examined 60 “multiple re-referral cases” and found that most of these cases were open to a range of universal, community based (not-for-profit and private providers), but intervention was ineffective. We concluded that the most common reason for non-response on the part of the local authority to referrals, was that the case was already open to another service. This finding indicates unintended, but nevertheless systemic weakness in multi-agency multi-provider working. We found that lack of effective intervention in these cases led to an escalation of risks for children and young people, resulting in more costly interventions. As a consequence it is suggested that improved monitoring of re-referral cases is important, following the recommendations laid out in the Munro review, at the level of the “child’s journey”.

2.5 Very detailed analysis of cases (4–6 hours of case profiling per case) to produce a full case history for 20/60 multiple re-referral cases, found that in every case, there was escalation of risk, clear evidence of both neglect and child maltreatment with a late response on the part of the local authority often resulting in the reception of children into care.

2.6 We concluded that the re-referral indicator is useful and should be retained as a measure of service effectiveness—but requires further differentiation to maximise its utility for local authorities in terms of service development. Analysis of multiple re-referral cases can provide LAs and partner agencies with critical information about systemic weaknesses.

2.7 Recent research found very variable use of CAF—sometimes completion of the form amounted to a couple of sentences only faxed to the LA to request a statutory assessment. In other instances, specialist workers, such as midwives with a definitive drug liaison brief were leading effective multi-agency assessment and intervention under CAF/Team Around the Child (TAC) arrangements in regard to pre-birth preventative work.

2.8 We found variable effectiveness of TAC arrangements. Many re-referrals to the LA were on account of failed TAC plans and teams.

2.9 We found that in regard to child in need cases, where the LA undertook a core assessment, rather than initial assessment and used the assessment process to engage parents, children and young people, as well as relevant professionals, subsequent transfer of this work to a TAC plan worked better. Members of universal and community based services felt better able to serve as Lead Professionals where a plan had been drawn up/ overseen by a qualified social worker located in the LA and that a transfer meeting was held to transfer a case from the local authority to TAC, with clarity about roles and responsibilities.

2.10 There are clear boundary tensions between the local authority and universal services around complex level 3 family support work, where there can be serious issues of neglect. Universal services often expressed not wanting to hold Lead Professional responsibility for cases that are borderline child protection—feeling that they have neither the authority or the ability to effect change. There are problems of these cases falling through the boundaries of services with a tendency for these cases to escalate in terms of presenting risks.

2.11 New risks to children, arising as a consequence of new media require a different approach to identification of risk. Risks to children and young people can cut across age and social class in ways that are less easy to detect by traditional universal or targeted services. Lancaster University has pioneered new ways for children themselves to identify risks from online predators with tests demonstrating much potential application but there is a great deal more to be done in this area.

3.0 Qu: Factors affecting the quality of decision-making in referral and assessment, and variations across the country

3.1 A recent analysis of re-referral patterns found that variability in response on the part of local authority teams was clearly associated with problems of staff resources. Of a study of nine teams within a single LA, the highest rates of re-referrals were recorded in two district teams that were encountering/had encountered the most serious deficits in staffing resources during the period under review. Deficits in staffing related to not just the number of qualified social workers employed in teams but also combinations of: lack of experience in qualified workers, high sickness levels, problems of leadership, problems of relationships between local authority teams, problems of relationships between local authorities and external agencies.

3.2 In this study, teams with the highest levels of capacity were those with more qualified social work staff, elements of preventative services were co-located and relationships were highly conducive to effective co-operation and communication. These teams were offering/co-ordinating a very impressive and effective early response.

3.3 In this same study we noted variable responses to self-referrals from children, young people and parents.
3.4 Some LAs are still requiring the completion of initial assessments within seven days, this continues the pattern of scant probing of concerns and poor, ill-informed analysis as reported by CWRU* and cited as key evidence in the Munro Review of Child Protection.

3.5 Agencies of health, welfare, education and criminal justice continue to manifest problems of differentiating risk in cases of domestic violence. A particularly problematic pattern of response to domestic violence lies in assuming that if children are not present at the scene of violence, that they are safe. This relates to insufficient understanding of the vulnerabilities of mothers and the inter-relationship between the safety of mothers and the safety of their children. In some cases we have found that analysis had not sufficiently identified risks posed to children through contact with violent men.

4.0 Qu: Appropriate thresholds for intervention, including arguments for and against removing children from their families

4.1 Research evidence consistently identifies the combination of risks that will likely result in the need to remove children from their families; however, our research work undertaken over a number of years, suggests that combinations of factors that include substance misuse, domestic violence, history of previous removals and so forth, can only serve as predictors, they do not determine significant harm in every case.

4.2 An evaluation of a pilot project located in two local authority areas is currently being undertaken (CAFCASS Pre-proceedings Pilot—interim report due November, 2011). This work has found that where local authorities are significantly invested in a pre-proceedings process that excellent results can be achieved in terms of support/rehabilitation of parents to prevent care proceedings. We are seeing high levels of diversion through very significant changes in parental substance misuse, mental health, family violence and general parenting capacity. These outcomes defy predictions but underscore the importance of considering questions about removal on a case by case basis.

4.3 Within the CAFCASS pilot, the Children’s Guardian becomes involved at a pre-proceedings stage and the input can shore up diversion plans, stimulate parental engagement and provide a level of independent scrutiny. The pathways that children take (remain with family/are received into public care) result from the interaction of service capacity and parent/family capacity—rather than just the latter.

5.0 Qu: Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

5.1 As part of the CAFCASS pilot evaluation we are currently carrying out, there is a clear tension for parents’ solicitors between representing parents and working in the interests of children in question. This tension will be further explored if and when HMCTS clearance grants the research team access to court files. However, evidence from interviews with professionals involved in Public Law cases, suggests that some adjournments of final hearings (which would settle permanence plans for children) result from parents’ solicitors requesting further assessments and so forth, that are unrealistic and are not in the best interests of children.

The key studies to which this evidence refers:

(i) A two year ESRC study (2007–09) graded outstanding, that included an examination of systems of initial assessment and referral in five local authority areas and is cited as key evidence in the Munro Review (Project led by Professor Sue White [formerly of Lancaster University] with Dr Karen Broadhurst in collaboration with an inter-university team).

(ii) A follow-on study in a large Shire authority that has specifically probed questions regarding thresholds, through detailed analysis of referral behaviour and the responses of nine district teams. Work is as yet unpublished, but a confidential report can be made available. This study developed a new approach to identifying and analysing multiple re-referral cases which clearly indicate children slipping through the net of preventative services (60 cases). This study also included analysis of the use of the Common Assessment Process (CAF) and the Team Around the Child (TAC) process, drawing new insights about referral behaviour in non-social work agencies and key reasons why the TAC process can fail (Project led by Dr Karen Broadhurst with an inter-university team).

(iii) A 12 months on-going study of the pre-proceedings process in three local authority areas that offers new insights into the possibilities for safe diversion of “edge of care” cases (55 cases). Within this pilot, the CAFCASS Guardian becomes involved in pre-proceedings work, with evidence of this new role leading, in some cases, to more robust diversion plans and better engagement of parents. (Project led by Dr Karen Broadhurst with Kim Holt of Bradford University).

(iv) A three year EPSRC/ESRC funded ISIS project that is developing tools to promote online child safety. This work is led by Professor Awais Rashid with Professor Corinne May-Chahal. A full account of this work is available at: http://www.comp.lancs.ac.uk/isis/

(v) A series of linked ESRC funded doctoral studentships.
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REFERENCES


ii A confidential report is available from Dr Karen Broadhurst, Lancaster University

iii A confidential report is available from Dr Karen Broadhurst, Lancaster University

iv A comprehensive programme of interdisciplinary research is on-going, arising from collaboration between the Department of Applied Social Science and the Department of Computing at Lancaster University, in conjunction with agency and inter-university networks. Full details of this programme can be found at: http://www.comp.lancs.ac.uk/isis/


October 2011

Written evidence submitted by Family Rights Group

1. Executive Summary

The engagement of families is key to keeping children safe when they are subject to child protection plans, not least because by far the majority of children under child protection plans live at home (92%).

Looking at “what works” in terms of the effective engagement should therefore be a key part of this inquiry because it is their families who are responsible for their day to day care. If they do not engage with the child protection plan, their child may well continue to be at risk, often unbeknown to professionals.

An effective child protection system must therefore involve putting in place a support structure that enables families to be able to take responsibility for their children’s safety, including:

— Easier access to services they need to stop problems escalating into child protecting concerns; and

— assisting families to recognise and take ownership of the plans necessary to keep a child safe, in order to avoid unnecessary proceedings.

Summary of our recommendations:

1. That Government ring fences funding for early intervention projects/family support that have a demonstrable impact.

2. That all families are encouraged and supported to take the lead in making a safe plan for their child, when concerns are identified (consistent with new Dutch legislation). This would be best achieved by all parents/carers whose children are subject to child protection enquiries.

   (a) having access to independent specialist advice. Families would need to be routinely given information about the advice service by local authorities when child protection (s.47) enquiries begin and long term government funding for the service would need to be put in place;

   (b) having access to an independent advocate, with expertise in child care law and practice, to help them participate constructively in the child protection process. This would involve the Government placing a duty on (and providing relevant funding to) local authorities to commission such specialist independent family advocacy services; and

   (c) being routinely offered a family group conference (FGC) to develop a plan to safeguard the child which addresses the local authority’s concerns.

3. That Family Mediation providers are encouraged to raise awareness both amongst mediation services and social workers of the potential role of mediation to support partnership working, assist parties to resolve disputes and agree a plan in child protection work.

4. That government guidance be revised so as to require local authorities to send the letter to parents before proceedings, either after the first review child protection conference or three months before proceedings are likely to be initiated (unless there is an emergency), whichever is earlier. This would maximise the opportunity for parents and wider family to have a last chance to address concerns and, where necessary, to identify options within family placements, prior to court proceedings.

5. That a coherent family and friends care framework be developed, so as to enable more children to safely live within their family, when they cannot remain safely with their parents. This would require a legislative lead including:


25 DCSF: Referrals, assessment and children and young people who are the subject of a child protection plan, England—Year ending 31 March 2009
— a new duty on local authorities to provide a support framework for all family and friends carers, including help with managing contact and support groups for such carers, irrespective of their legal status;

— a right to an assessment to support for children being raised in family and friends care arrangements;

— a national financial allowance when there is judicial or professional evidence that the children cannot live with their parents; and

— non means and non merits tested public funding to enable family and friends carers to apply for a legal order which provides a child, who cannot remain at home with their parents, with permanence.

We would welcome the opportunity to explain them further in oral evidence, including options as to how they could best be brought into practice.

2. About Family Rights Group

Family Rights Group advises and supports parents and wider family members in England and Wales who are involved with, or require, local authority children’s services, about the needs, care and protection of their children. The Charity was founded in 1974.

We promote the involvement and support of family members in making safe plans for their children which will enhance their welfare. We campaign to challenge injustice, to improve access to effective services, and to increase the voice children and families have over decisions affecting their lives. Our free telephone and email advice service advises 6,500 parents and relatives per year about their legal rights and the options open to them.

This submission is informed by our extensive experience of advising parents, carers and wider family members who are involved with children’s services about child protection concerns and processes.

3. The Importance of Engaging Families to Secure the Safety and Well-being of Children at Risk

3.1 Context

All of us are born into and live our lives through relationships; those with our families of origin are of central and enduring significance. We may not be able to keep all such families intact but the removal of a child from their family is one, if not the, most draconian actions that the state can take. There is ample evidence that such children have to make sense of that throughout their lives and that relationships endure in memory long after they have ceased in practice.

Most children live within their families. 92% of children who are subject to a child protection plan live at home, hence it is their families who are responsible for their day to day care. It is therefore unsurprising that research confirms, that family engagement is key to keeping children safe when they are subject to child protection plans.

Whilst the Baby Peter case demonstrates that seeming maternal co-operation isn’t sufficient on its own for children’s social care services to be confident that a child is protected, the absence of partnership working between the family and the social care agency is an important indicator of serious concern. Indeed a lack of parental cooperation is a key factor as to why cases end up in proceedings. Yet, our current child protection process is poor at engaging with families.

In our view, it would not only be unwise, but also potentially dangerous, to propose changes to the safeguarding system without a key focus being the importance of working effectively with families to secure the safety and well-being of children at risk.

Drawing on our practice experience, we therefore set out below our analysis of the obstacles and opportunities for effectively engaging families in child protection work.

3.2 The obstacles to family engagement in keeping children safe

Lack of parental engagement is complex—and linked to many factors. It is often difficult for parents, carers and wider family members to understand local authority concerns and to engage during s.47 child protection enquiries because:

— They are often unclear about the totality of the concerns and the reasons for them—they may be given information in a series of different conversations and/or local authority social workers are often unclear themselves about the nature of the underlying problems that need to be addressed and at times may give contradictory views. This has been a particular difficulty in the current climate of targets and time pressures.

26 DCSF: Referrals, assessment and children and young people who are the subject of a child protection plan, England—Year ending 31 March 2009

— They are frightened, angry and confused which prevents them from hearing what is being said by the local authority, and they often don’t know where to turn for advice.
— They often don’t understand the processes and are overwhelmed by continuous assessments and meetings in which they are under the spot light of a large numbers of professionals.
— The fear that the child may be removed by the local authority makes it hard for them to trust and to work openly with social workers, to reach agreement about how their child should be kept safe.
— The system doesn’t support families to take responsibility; instead parents often feel decisions and actions are done “to” rather than “with” them, thus encouraging a sense of dependency and resentment. Practitioners need to be managed, supported and equipped to work with families in ways that are high in support and high in challenge.
— Social workers’ attention is rarely spent engaging with non-resident fathers to assess them as a risk and/or resource; instead our child protection system is predominantly focused upon on the ability of the mother to protect the child. A file audit of children in need and child protection cases involving domestic violence found that there was a lack of assessment and information about the parenting capacity of 61% of the fathers (Ashley, 2011).
— Social workers’ focus too often is on a narrow view of family, thus, the “capital”, in terms of potential care and support to the child from the extended family is overlooked.
— There is clear evidence of the protective impact of wider family (in particular the fact that they are frequently responsible for the initial referral to children’s services when there are serious concerns about their child in the parents’ home) yet current practice frequently fails to recognise this.

The financial climate is exacerbating the situation because many non-statutory services are being closed, making it much harder for families to access the specialist, non-stigmatised support they need when problems first emerge. Many of the families who call our advice service are those who then reach crisis point and whose children become subject to compulsory state intervention through the child protection (or youth justice) systems.

A number of prevalence and incidence studies have highlighted the link between poverty and forms of child maltreatment, especially neglect, emotional and physical abuse. Explanations centre on the stress factors associated with poverty and social deprivation, including unemployment and debt, which are compounded if drug misuse and mental health issues come into play (Dawson, 2008). Although there is no published research on the impact of the recession, it is likely that increased poverty in vulnerable families is one of the factors leading to children’s services teams being overwhelmed by referrals and care proceeding applications being at record levels (although there is some local variation across the country).

The Munro report recognises that early intervention can prevent problems reaching 3rd and 4th tier services, thus ensuring fewer and more appropriate referrals. However, the tide at the moment appears to be in the opposite direction. What we currently face are:
— long, expensive delays within the court process;
— children not being allocated guardians until late into proceedings;
— a shortage of foster carers; and
— children facing insecurity whilst awaiting decisions about their futures.

Arguably, the biggest casualties of such failings have been vulnerable children and families.

4. The Underpinning Values of an Effective Child Welfare System

We set out below our proposals for the effective engagement of families in this context. These proposals:
— support partnership working between families and the local authority, in order to ensure children who are at risk of harm are kept safe; and
— enable more children to remain safely living within the wider family network, if they are unable to live with their parents.

The intended impact of our proposals is to improve outcomes for children and it is critical that this is the driving force behind any reform. But they also have the added benefit of reducing avoidable care proceedings and saving social work and court costs in the process. The proposals are cost effective—generating savings in the court system, the legal aid budget and local authority budgets. For example:
— Every unnecessary care case avoided, saves more than £25,000 associated with the court process alone.
— Even a reduction of 5% in the care population could reduce expenditure on the care system in England and Wales by over £100 million per annum, which could be more effectively redirected to promoting children’s welfare.

29 Dyson, 2008 Child Protection Research Briefing Poverty and child maltreatment (NSPCC)
5. KEY RECOMMENDATIONS FOR EFFECTIVE FAMILY ENGAGEMENT IN CHILD WELFARE: WHAT WORKS?

5.1 Early intervention and family support

The economic and ethical case for early intervention has been made (see Lonne et al, 2009, Munro review 2011, Allen review, 2011) and needs to be a fundamental part of a child welfare and protection system. Therefore changes in child protection need to be located within a wider child welfare framework that includes family support and early intervention. Such strategies must be at the heart of the system, rather than being considered to be optional extras and the first things to be cut when there are financial pressures.

We are deeply concerned that a rise in referrals and funding cuts is putting unsustainable pressures on children’s services’ budgets. We are therefore witnessing local authorities closing family support services, on the basis that they aren’t statutory, despite their demonstrable, beneficial impact.

It is going to be increasingly critical that the resilience of our “universal” services (some children’s centres, schools, primary health) is bolstered through co-located specialist expertise (social work, Family Nurse Partnership, targeted family support workers etc), so that needs can be met and risks assessed at a point sufficiently early to avoid escalation into higher cost interventions. Success will depend upon:

— the capacity in universal provision;
— professionals having greater expertise and increased confidence; and
— ensuring that practice is inclusive, collaborative and engaging of families.

**Recommendation:** We support the ADCS proposal that Ministers ring fence funding for early intervention projects/family support that have a demonstrable impact. Further, we support the development of integrated, targeted provision within universal services, building capacity and developing practice models that recognise and support the central role of the family in protecting children.

5.2 Supporting parents/carers to engage with child protection processes

5.2.1 Independent specialist advice for parents/carers when s.47 enquiries commence

Even if child welfare processes were simplified, it is still critical that parents and family members are able to discuss with a specialist independent adviser how the system works and the realistic options open to them and, indeed, how they can constructively challenge. A recent independent evaluation of such advice provided by Family Rights Group’s Advice Service\(^\text{31}\) found that:

— 88% of family members who had called the advice line felt it had helped them to cope with their situation;
— 100% of grandparents felt that their chances of contact with a grandchild had improved following their call;
— 90% felt more confident in their dealings with social workers/professional; and
— 60% reported that the advice they received had helped the family to stay together. 88% reported that as a result of their call, they had acquired more understanding of their situation. This was linked to a reduction in abnormal psychological functioning, that research suggests is linked to improved parental functioning.

For an illustration of the role of specialist adviser for parents in child protection, see case study 1 in Appendix 1.

Family Rights Group’s advice line is funded by the Department for Education until June 2013. Thereafter there is currently no provision for further funding.

**Recommendation:** That all families subject to child protection enquiries have access to independent specialist advice, such as that provided by Family Rights Group’s advice service and information. Families would need to be routinely given information about the advice service by social workers when s.47 enquiries begin and long term government funding for the service would need to be put in place to fund such advice.

5.2.2 Independent advocacy for parents/carers in child protection processes

Independent advocacy for parents in the child protection process has been found to have a very positive impact on partnership working, enabling the parent to hear the concerns, engage in the child protection conference and focus upon the child’s needs rather than be caught up in hostilities with the local authority.\(^\text{32}\) A recent evaluation of FRG’s advocacy service\(^\text{33}\) found that:

— 73% of clients reported advocacy had made it easier for them to communicate and work with the local authority;

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\(^{31}\) Ritchie C (forthcoming) Evaluation of Family Rights Group’s Advice Service


\(^{33}\) ibid
— In 79% of cases, the conference chairperson felt that advocacy support had increased the level of parental engagement with the local authority. In 35% of cases, a different outcome for the child was linked to increased parental engagement.

“Without the advocate I do not feel we would have been able to draw up a child protection plan that involved the mother and had her agreement.” (Conference chair)

Research has found that what makes a difference is that the advocate has specialised knowledge of child care law and practice, is non-confrontational, works to a reporting threshold and is independent of the local authority. It is particularly important that vulnerable adults, for example parents with severe mental health or learning difficulties, have access to an advocate. However, there is no national provision of specialist advocacy for parents in local authority safeguarding processes.

For an illustration of the role of an advocate for parents in child protection see case study 2 in Appendix 1.

**Recommendation:** That all parents/carers whose children are subject to child protection enquiries, have access to an independent advocate in the child protection process, with expertise in supporting adults with their particular vulnerability as well as child care law and practice. Linked to this would be new duty on local authorities to commission such specialist independent family advocacy services (supported by central government funding).

5.2.3 Family Group Conferences (FGCs)

FGCs originate from New Zealand. They are decision making meetings in which plans are constructed by the family (including extended family members and friends) which addresses the identified child protection concerns to ensure the child’s future safety and well-being.

An FGC is convened by an independent co-ordinator who is employed by a local FGC service which is part of, or commissioned by the local authority or local agency. The co-ordinator visits and prepares the young person and family members, including wider relatives and friends who have an interest in the child. The meeting consists of three stages:

(i) the information giving stage during which the social worker and other key agencies set out the concerns that must be addressed within the plan;

(ii) private time when the family (the agencies and co-ordinator should not be present) construct the plan; and

(iii) the agreement stage when the local authority/key agencies agree to the support plan as long as it is safe.

The child normally participates in the FGC and should be offered an advocate to help ensure their voice is heard. A DVD entitled “What is a Family group Conference?” is being sent to the Committee under separate cover. For an illustration of the impact of an FGC see case studies 3 & 4 in Appendix 1.

FGCs have been successfully held in situations where there has been substantial abuse including domestic violence (AHA 2009, Pennell and Burford 2000). These positive outcomes are not just in the immediate period after the FGC; a longitudinal study by Kiely and Bussey (2001) demonstrated a reduction in reports to child welfare statutory services post FGC conference. This finding was echoed by Titcomb and Lecroy (2003) who found that 87% of children did not have a substantial report of abuse or neglect up to three years following the meeting, and by Pennell et al who found that families suffered less maltreatment following an FGC (Pennell and Burford 2000). Moreover, FGCs are proven to:

(i) Result in extended family members stepping in to support struggling parents and when necessary to take on the care of the child if s/he cannot remain with their parents;

(ii) Engage fathers and paternal relatives more effectively than existing statutory processes;

(iii) Give children a voice;

(iv) Improve outcomes for children at risk; and

(v) Be cost effective in preventing children being unnecessarily subject to care proceedings or removed into care. For example, a survey by Family Rights Group of nine projects reported that they have prevented 229 children becoming looked after in the last year, including avoidance of proceedings for 116 children, and that FGCs had led to 58 children returning to their family from local authority care. The combined savings from this amounted to an estimated £11,005,167. The combined FGC project budgets amounted to £1,467,700 in 2009–10 and whilst costs to public agencies of supporting

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35 Further information about how they work can be found in a Protocol, endorsed by the Family Justice Council and CAFCASS, on the use of FGCs for children who are or may become subject to care proceedings—see http://www.frg.org.uk/pdfs/FINAL+FGCs+and+courts.pdf

36 op cit

37 op cit

38 op cit

39 op cit
the family plan must also be taken into account, nevertheless the savings are clear—for further information see Appendix 2.

Since their inception, FGCs have been subject to considerable research and the evidence base for their impact is clear (clearer, in fact, than for traditional child protection conferences). Yet, despite an expansion in the number of child welfare FGC services in recent years and a recommendation in recent government guidance that local authorities should have an FGC service to assist in identifying support in the wider family for children at risk:40

— Around 25% of local authorities in England and Wales still do not have any FGC service and none is planned. Even in those authorities that do have one, whether or not families are offered an FGC largely depends upon the social worker. It is only a small minority of authorities which have a policy to offer an FGC to all families, prior to proceedings being taken/a child being looked after.

— Many FGC services are focused upon the “high” end, in other words cases which are close to proceedings being issued, yet families often state that they wish they’d been offered an FGC early on when problems first emerged.

— Whilst FGC services are being developed for the first time in some local authorities,41 in others they are closing or being scaled down, or the principles upon which they work are being compromised, as a result of funding cuts, because they are non statutory.

It is worth noting that in the Netherlands, recent legislation provides that families are given six weeks to develop or amend an action plan for the child before proceedings can be commenced to remove a child (other than in an emergency which is addressed separately). Although the legislation doesn’t specify how the family should construct such a plan, one clear route would be through a family group conference.42

**Recommendations:**

(a) That the law is amended in line with the Netherlands, so that families have lead responsibility in creating a safe plan for the child within six weeks of concerns being identified, except in emergencies;

(b) That an FGC is routinely offered to families to develop a plan to safeguard the child, when an initial child protection conference has determined that a plan is required.

(c) That there is a new duty on local authorities that all families are offered an FGC prior to care proceedings (or in an emergency immediately afterwards).

5.2.4 Family mediation services

As suggested in the Family Justice Review Interim report, greater use could be made of family mediation to resolve disputes between family members and the local authority in child protection processes for example, about aspects of the child protection plan instead of resorting to court proceedings where agreement cannot be reached. Although not yet widely used in this context, some Family Mediation Services (for example Cambridge) already have experience of mediation in child protection/public law cases.

**Recommendation:** Family Mediation providers should be encouraged to raise awareness both amongst mediation services and social workers of this potential intervention which can support partnership working, so that referrals are appropriate and timely.

5.2.5 Letter before proceedings

Following a recommendation in the Review of Child Care Proceedings (2008), Government guidance43 requires local authorities to send parents/carers a letter when care proceedings are being considered, to inform them about the concerns and what needs to be done to address them, so as to avert care proceedings. This letter typically invites them to a meeting to discuss the concerns and also entitles parent(s) and others with parental responsibility, to obtain free, independent advice (Level 2 public funding) from a solicitor and assistance with negotiations.

In our experience, parents generally find this letter very helpful, though, it is often the first time they can see clearly the extent of the concerns, how they must be addressed and the seriousness of the situation.

However, in reality its use is patchy and in some areas is still being sent so late in the day that there is no time for parents/wider family members to make the changes necessary to overcome the concerns before care proceedings commence.

41 Family Rights Group was funded by the then DCSF to promote the wider use of Family Group Conferences across the country 2009–11. It continues to receive funding from the Department for Education to provide free consultation to local authorities wishing to set up FGC services.
5.3 Family and friends care

A child can only be removed from their parents (or others with parental responsibility) if:

(a) the parents/others with parental responsibility agree (for example via an FGC); or

(b) the court makes an emergency protection order (EPO) or a care order (CO) to authorise them to remove the child without parental agreement.

Once a child is removed, the first choice of placement for a looked after child is with relatives or friends before considering unrelated carers, provided the child will be safe.44 This means that many children who cannot remain safely at home with their parents end up with family and friends carers, whether their parents agree or not. This is consistent with the child’s right to respect for family life (Article 8 ECHR) and with research evidence which shows that despite not receiving adequate support, the outcomes for children living in family and friends care are comparable to, if not better than, those of children who are living with unrelated foster carers.45

Family and friends care is therefore a really key resource for children at risk of harm because it is likely to be the best alternative for children who cannot remain safely in their parents home. Yet:

(a) There is a failure to identify potential family and friends carers early by the local authority which can lead to a child who is removed from their parents home being placed in unrelated care before later moving to live family or friends, causing the unnecessary disruption and trauma.46

(b) Failure to provide adequate support for children in family and friends care: Research47 has found that children in family and friends care have generally suffered the same adversities as those in unrelated foster care and their carers are poorer and are living in far more disadvantaged circumstances than unrelated foster carers, yet family and friends carers receive little if any support to raise these vulnerable children. This is largely attributable to the fact that most children in family and friends care are not “looked after” and therefore there is no duty on the local authority to support the arrangement.48 This can cause particular problems:

— **Financial support:** Such carers do not receive adequate financial support to compensate them for the often significant additional costs of taking on a child who is not theirs.49

— **Contact:** Family and friends carers are often left alone to manage contact between the child and parents, despite this being extremely fraught (it might be their own son or daughter whose access to their grandchild, they have to severely restrict), costly and sometimes leading to further litigation.

— **Legal costs:** Currently public funding for a family and friends carer who is seeking a residence or special guardianship order (to provide legal security, and give them parental responsibility, for the child who is living with them) is means and merits tested (unless the applicant already has parental responsibility and is involved in care proceedings). Hence any relatives with savings of more than a very modest income cannot obtain public funding. Many carers end up either being litigants in person when they make an application to court or in debt, as a result of legal costs paid out.50

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44. S.22C Children Act 1989 as amended by s8 CYPA 2008.
46. This is confirmed by FRG’s recent internet survey on family and friends care (forthcoming) which suggests that over 20% of children in family and friends care live with unrelated carers before moving to live with relatives or friends. For more information contact Cathy Ashley (cashely@frg.org.uk).
48. Note: the local authority is under a duty to provide support to looked after children, including assistance in managing contact with parents, other siblings etc; priority school placements; leaving care planning; allocation of a social worker and independent reviewing officer for the child and, their carers are foster carers who are paid and should have access to training, support groups etc. But, it only has a discretionary power to provide support for non looked after children in family and friends care (for example where relatives have stepped in at an early stage to look after children who are subject to child protection enquiries to avoid them being taken into care) which means they do not have to provide support to such children.
49. For example, a survey by Family Rights Group of 205 family and friends carers in January 2010 found that 35% had left their job, lost their job or taken early retirement to raise these children and over a third had spent more than £1000 making changes to their home and getting things the child needed, when the children came to live with them.
50. For example, the January 2010 survey of family and friends carers found that the average legal costs to secure the child’s future (through a residence order or special guardianship order), was £3,640, with the majority of carers receiving no financial help towards these costs. 82% of carers who spent over £10,000, were self-funded.
Moreover, if the provisions to reform legal aid are enacted as currently drafted in the Legal Aid, Sentencing and Punishment of Offenders Bill, relatives and friends (who would otherwise be eligible for public funding under the means test) will not be able to get advice about the implications of taking on the care of a child at risk unless there is already existing evidence of alleged harm (ie under a child protection plan or subject to care proceedings). This is likely to act as a disincentive to relatives seeking to protect a child by stepping in early when problems first emerge.

Recommendations:

(a) The above proposals regarding FGCs (para 5.2.3) should assist to identify wider family members at an earlier stage.

(b) There needs to be a legislative amendment to provide a coherent family and friends care framework, addressing the provision of assessment and support for all children in family and friends care, irrespective of whether the child is looked after or not. This would include:

— a new duty on local authorities to provide a support framework for all family and friends carers, including help with managing contact and support groups for such carers, irrespective of their legal status;

— a right to assessment for support for children being raised in family and friends care arrangements;

— a national financial allowance, when there is judicial or professional evidence that the children cannot live with their parents; and

— non means and non merits tested public funding to enable family and friends carers to apply for special guardianship or residence orders where children cannot remain safely with their parents, whether or not children’s services are involved.

APPENDIX 1

CASE STUDY 1: IMPACT OF SPECIALIST ADVICE FOR PARENTS

 Caller was a married man who had adopted three children: girl (12 years) and twin boys (11 years). He called FRG’s advice line for advice about his daughter. She was due to have urgent therapy following the adoption (to help address significant trauma she had suffered prior to the adoption) but none had been provided either by the original local authority which had the care order or the one in which his family lived.

 Both the caller and his wife felt extremely let down by the local authority and made frequent complaints regarding the lack of support their daughter had received and the continued problems she and the family were suffering as a result. Children’s services instead were convening a child protection conference which placed the daughter under a child protection plan for emotional abuse. The review conference is due this week.

 The caller said that a report had been prepared by Family Futures (a specialist adoption support agency) which states that this is a successful adoption as Mr and Mrs W clearly love their three children and are committed to their daughter but that they believe she needs therapy, rather than there being a problem with their parenting.

 The FRG adviser discussed the child protection review with the caller who said that he and his wife did not want to attend the review conference as they felt “completely powerless, lied to and ignored when they attended previous meetings”. He also had just started a new job, following redundancy, and was therefore worried about taking time off so soon. The FRG adviser discussed the importance of parental engagement in the child protection process and advised that:

— professionals might interpret their non-attendance as evidence of their disinterest in the plans for the children; and

— if they did not attend, they could not comment on any proposed new assessments and/or advocate on their daughter’s behalf.

 Despite causing him inconvenience with his work, the caller agreed that their attendance at the conference would be best, but if that was not possible, he would write a letter for the social worker to give to the team manager and the Conference chair addressing the following points:

1. The parent’s continued commitment to working with professionals for the benefit of the children.

2. Their continued desire for a referral for counselling for their daughter.

3. His apology for being aggressive (his words) towards the team leader in the past which had occurred as a result of pure frustration.

4. The need for early notification of the next core group which he would endeavour to attend or ask to be arranged at his home so that his wife could attend because she is a full time child minder.
CASE STUDY 2: INDEPENDENT ADVOCACY FOR PARENTS IN THE CHILD PROTECTION PROCESS

Case involved a family of three children. The local authority was not concerned about the two eldest girls but the youngest, a six year old boy, was presenting extremely challenging behaviour and the school had contacted the local authority regarding a disclosure from the boy that his father beat him and to a lesser degree his sisters. When father attended the school and was greeted by the social worker he was very upset. The school contacted the police as the deputy head felt that father was threatening. This was not supported by the social worker. Unfortunately there were no child protection officers available so uniformed officers attended the school which upset the parents further. The parents were of Iranian heritage and believed that the Deputy Head was being racist by calling the police to arrest father which did not happen.

Following a referral by, and with funding from, the local authority, FRG’s advocate spoke to the parents and ascertained that they did not want to go to the child protection conference because they felt that the professionals would be racist, would not understand their culture and would try to take their children away. They said they had been begging the school for help with their son since he started in the nursery two years ago. He had started to receive help and then without explanation it had stopped. He now had serious behavioural problems which included smashing up his classroom because he did not want to go outside to play on a cold day. He had also bitten and kicked the Deputy Head when his class teacher called her to calm him down, resulting in her ending up in hospital. FRG’s advocate obtained a copy of the social worker’s report and went through it with the parents and also ascertained their wishes for their child before the conference. She then persuaded them to attend the conference, with her as their advocate, to tell professionals that they still wanted help and were willing to work with professionals. At the conference both parents were extremely vocal about how much they did not trust the professionals, especially the school and local authority. The advocate intervened on their behalf and pointed out specific areas where professionals had failed to inform them of important factors, such as receiving no explanation as to why classroom support had been withdrawn: it transpired that the school perceived the child’s behaviour had improved improving so much that they decided to discontinue this support because of funding issues.

Following the conference the family felt that they had been heard and that they were able to put items on the plan for the children. More importantly, the father felt that someone, including Family Rights Group was actually listening. The advocate subsequently accompanied them to the first core group meeting which was productive. The parents had adhered to the plan and had actively sought advice from the new social worker on other issues and acknowledged her support at the meeting. Things worked so well that at the first review it was decided that the matter should revert to a Child in Need plan.

CASE STUDY 3: IMPACT OF A FAMILY GROUP CONFERENCE

S was a young mother with two small children and heavily pregnant with her 3rd. She had experienced significant domestic abuse during the early stages of her pregnancy and her partner was no longer living at the family home. He also had only supervised contact with the children.

A referral was made to FGC service during the latter stages of S’s pregnancy to consider how the unborn child and her older children could be protected and how S could best be supported after the baby’s birth. There were concerns that S may be vulnerable to seeking support from her ex-partner and her ex-partner was saying that he wanted to be at the birth and support S with childcare.

The FGC

The FGC was attended by S and five of her extended family. It was also attended by three of the paternal family. The father of the children was not invited to the FGC and though the children’s views were sought they were also not involved in the FGC because of their young age and the subject matter under discussion of the FGC.

At the FGC a birth partner was identified from within the family and the paternal family agreed that they would help to ensure that he did not attend the birth. It was agreed that the hospital would be informed and that he would be asked to leave if he came to the hospital.

Following the birth of the baby S’s sister would move into S’s house temporarily and support S with the new baby. Her mum would take the older children to school and nursery.

It was agreed that until the review meeting S would not be left alone and family would pull together to support S with her children and to prevent the vulnerabilities that may result in her seeking support from her ex-partner.

CASE STUDY 4: IMPACT OF A FAMILY GROUP CONFERENCE

S is the mother of girls B (10yrs) and D (12yrs). She has another daughter C who has lived with her father since summer 2009. S is currently in a relationship with I. Their relationship is very important to each another. Children’s services however, was concerned about drinking and arguments which sometimes resulted in violence. The children overheard these arguments and had also seen bruising on their mother. They were aware
of times when the Police have visited the home because of the domestic violence. Both girls clearly love their mum who when sober is caring and kind.

Both girls have informed the social worker that they would prefer to live with people other than their mum. Following discussion with mum arrangements were made for the girls to live with wider family and the girls were settled in these arrangements in the lead up to the FGC.

The Agenda of the FGC

The FGC was asked to address issues of contact with the mum, contact for the girls to see each other, and what supports were in the wider family to support the kinship placements of the children.

What if the situation wasn’t resolved?

The social worker expressed concerns for the on-going welfare of the children and the likely need to pursue a legal solution if the family were unable to resolve these concerns.

The FGC

After six weeks of planning an FGC was organised involving 12 family members including the children, the meeting was also attended by the social worker and the FGC coordinator. Four family members who couldn’t be there made written submissions to the meeting.

The family made a plan specifying where, how and with whom contact should occur and specifying that it shouldn’t include mum’s partner. The children made a list of guidelines for how contact should proceed and what was not allowed (eg mum being drunk). And what would happen if this wasn’t complied with. Arrangements were made for police involvement in event of difficulties persisting in mum’s communication with the kinship placements.

The family made clear arrangements for respite care for periods of time with different relatives.

The plan was agreed including a review of the plan in three months.

Social workers’ views

‘I think the FGC for the girls were exceptionally helpful. It enabled me to meet all of the extended family in one swoop and between them they came up with support for the primary carers. We have not initiated legal action. It would be my view that if mother attempted to resume care then we would have no option but to do so as they would be unsafe in her care. The girls were very happy with the FGC’.
### APPENDIX 2

**COST SAVINGS RESULTING FROM FGCS**

**Table A**

**REPRESENTING SAVINGS MADE TO COSTS OF CARE AND LEGAL PROCEEDINGS RESULTING FROM THE FAMILY GROUP CONFERENCE**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>No of children prevented from becoming looked after/how evidenced</th>
<th>No of children returned to family from local authority care/how evidenced</th>
<th>No of legal proceedings prevented/how evidenced</th>
<th>Costs saved</th>
<th>Overall cost saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA1</td>
<td>82 Social work evaluation by data</td>
<td>3 Evidenced by refferer</td>
<td>No Data</td>
<td>£2,315,762</td>
<td>£2,400,485</td>
</tr>
<tr>
<td>LA2</td>
<td>38 Evidenced £1,073,158 by data</td>
<td>12 Evidenced by refferer</td>
<td>38 Evidenced £950,000 by data</td>
<td>£338,892</td>
<td>£2,362,050</td>
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*October 2011*

**Written evidence submitted by Dr Roger Morgan OBE, Children’s Rights Director for England**

**The Office of the Children's Rights Director**

1. The Children’s Rights Director has the statutory duty to ascertain the views of children within a defined remit of those in care, receiving children’s social care services, or living away from home in residential education, to advise on children’s rights and welfare, and to raise policy or individual case issues the Director considers significant to the rights or welfare of children within his remit. The Office of the Children’s Rights Director is hosted by Ofsted, has statutory duties to advise Her Majesty’s Chief Inspector, and carries out consultation and advisory functions at the request of government Ministers and officials.

2. This submission is made by the Children’s Rights Director, based exclusively on consultations carried out with children and young people within his statutory remit and published in children’s views reports, all of which are available on the children’s rights website www.rights4me.org. It gives ascertained children’s views, and not adult, personal or professional views. I know that the Committee have previously found having the input of “straight” children’s views of value.

3. The submission is made independently of Ofsted as the host organisation for the Office of the Children’s Rights Director, and does not necessarily reflect the views of Ofsted.

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51 Based on child being in care for 12 months costing £28,241. See table Costing care episodes of looked after children: standard costs to social services of case management processes (foster care) (Loughborough University cost calculator) in appendix

52 The figures take into account the estimate in the DfES/DCA/Welsh Assembly (2006) Review of the Child Care Proceedings System in England and Wales p13 that the cost of the court process alone in individual care cases amounts to £25,000.
RIGHTS AND RESPONSIBILITIES FOR CHILD PROTECTION

4. In a specific consultation with children on their views and priorities for both children’s rights and children’s responsibilities, the highest scoring children’s right was the right to be protected from abuse. The top scoring responsibility was responsibility for your own behaviour and actions, the fourth was responsibility for your own safety, the fifth was looking after others, and the sixth was looking after yourself.

FEELING SAFE

5. Each year we consult children in care, receiving social care services, or living away from home, for the Children's Care Monitor on the state of social care in England. In 2010, the latest published Monitor report, children felt safest in the building where they lived, next safest at their school or college, next safest in the countryside, and least safe in towns or cities. 94% of the children surveyed felt safe or fairly safe in the buildings in which they lived, and 72% felt safe or fairly safe in towns or cities.

6. The children consulted saw the top five dangers to themselves as being, in descending order, drugs, alcohol, strangers and kidnappers, knives and bullying. Children under 14 were more likely than older children to list strangers and kidnap as dangers, while those over 14 were more likely to list alcohol. Girls were more likely to list alcohol than were boys.

7. The children saw the most likely sources of accident to children their own age as road traffic accident, followed by the results of too much alcohol, followed by injury while being beaten up or fighting, falls, or the results of drug misuse.

8. 36% of children surveyed for the 2010 Monitor reported that they worried a little or a lot about their own safety. This was a reduction from the previous year.

9. In a specific consultation on safeguarding, children and young people advised of the factors that would make them feel safer. The top five were friends and family, police and the law, teachers and carers, keeping themselves away from bullies and gangs, and using their own common sense.

10. In a separate specific consultation with children under 12, these younger children nominated the two top factors keeping young children safe as their carers, and being with a caring adult. Fifth on their list, from 10% of these children under 12, was not talking to strangers.

11. In consultations for the Munro review, children told us that it is important that children and young people are able to discuss child protection issues with a professional in an environment that feels safe and encourages the child to be sufficiently at ease to be able to speak about highly personal issues. Children spoke of the importance of feeling that they can keep some control over what happens next and not lose control of everything to the adults they speak to, of being able to trust the adult involved, and of the adult not doing anything (such as getting their name wrong) to lose that trust. At a very practical level, children spoke of how it is helpful to have something to distract from the conversation when needed—such as something to fiddle with—and to be able to have something to eat or drink to help counter anxiety.

12. Children have also advised that holding consultations relating to personal issues or protection at school, where their peers will be curious, is counterproductive. There is a preference to hold such meetings on separate professional territory or neutral territory away from the child’s usual base.

WHAT CAN BE DONE TO KEEP CHILDREN SAFER?

13. In their consultation for the Munro review, children advised Professor Eileen Munro that keeping children safe is largely down to having responsible adults around children and young people. Criminal Records Bureau checks have an important role to play in ensuring this, but should not be used to the extent that children in care are unable to enjoy normal social contacts such as sleepovers with friends because their parents have not been police checked.

14. In the same consultation, children advised that if a professional is monitoring the safety of a child, that professional should regularly phone that child in private to check their safety, using mobile phone contact as necessary and frequently—even hourly—if needs be.

15. These children stressed the importance of making children and young people themselves aware of risks and boundaries. Knowledge and awareness are keys to keeping yourself safe. They advised that this should not just be a matter of telling children what to do or not to do, as children and young people will often do things they are told not to do. It should give children the awareness of dangers to help set their own safety boundaries for themselves.

16. Children have previously told us that realistic, even if frightening, information about the nature and risks of abuse can help children to protect themselves—even if this means giving younger children information that distresses them in order that they are motivated to avoid taking dangerous risks.

17. Children in our consultations for Munro have advised that adults working with children need to be more aware of the risks to children with disabilities.
18. These children also advised that in their personal experience, action taken if a child is being harmed needs to be quicker, smoother and more efficient.

19. They also advised that in each case a careful assessment needs to be made on whether someone harming a child can be removed from the home, or whether involvement of someone from the council will have a sufficient protection for the child, or whether it is still necessary to “remove the child from the risk”. The cost to the child’s life of taking them away from their existing life also needs to be assessed in making such decisions.

20. Children consulted for the Munro report were concerned about situations where there is insufficient evidence for formal action to be taken to protect a child. In such cases, children advised that the situation should still be closely monitored, especially if the child has disclosed harm. “Don’t just think because nothing was proved that it’s OK for the child to be at home”.

21. The children were also concerned that when abuse is suspected for one child, other children (including siblings) in the same home or establishment may be at risk too—but a different and separate assessment needs to be made for each one of them, and may lead to different actions for different children.

22. Children have stated to us that it is important that the child is consulted when action following a disclosure of abuse is being decided, and that their views, wishes, concerns and feelings are taken into account. Children have however also recognised that for many the adult professional needs to take charge and make decisions, having heard and considered the child’s views.

23. We also heard that children may be put off disclosing abuse or safety concerns to a professional adult because of lack of knowledge of what would happen next, being scared of some professional adults, fear of not being believed, or fear that the person they tell will pass the information on too widely, beyond strict need-to-know limits.

24. Children also expressed concern that professionals tend to believe adult accounts more than they believe accounts from children, which can be dangerous. They counselled that all sides of the story, including what children say alongside what adults say, should be fully looked into.

25. Children further advised that a child or young person will sometimes wait until abuse is over before telling about it, and may need a long time to think about it before they tell anybody. For some this means that nothing is said while abuse is actually happening, and when the child eventually feels able to tell someone, it is too late and probably nothing can be proven.

26. Consultees recommended that there should be a range of different ways for a child to relay concerns about abuse, including electronic means, as many find it easier to leave such messages rather than confronting a questioning adult directly with their account. Some will leave hints and hope that adults will pick these up for themselves.

27. In other consultations, children have identified safeguarding as overriding usual rules of seeking children’s permission before sharing information about them. However, children have advised that even so there should be significant limiting factors: information should only be shared on a strictly need to know basis and confidentiality otherwise preserved, children should if possible be told about information being shared about them, and information should only be shared if that sharing is judged to be more than likely to prevent sufficiently significant future harm to the child or another child or young person.

28. In early consultations on child protection, children and young people have advised that professionals and the public tend to think first of younger vulnerable children when thinking of child protection. However, older teenagers and young adults such as care leavers can be particularly vulnerable too, and child protection systems need to recognise and counter risks to these older young people.

29. Children consulted have countered the professional assumption that a child should not be required to retell their story to different people in child protection processes. Children’s advice on this has been that it depends on the child: some only wish to tell their story once, others wish to retain control of their story and retell it themselves if necessary rather than allow it to be eroded by others passing it on.

30. On physical restraint, children have advised of risks of injury through particular types of restraint or its use by inexperienced or untrained staff.

31. Many consulted in secure units have told us that they fear for their own safety on leaving security and returning to peer group pressures and risks.

**WHO CHILDREN WOULD GO TO FOR HELP**

32. In the 2010 Monitor children reported that the top four people they would go to for help if they were unsafe or at risk were a friend (58% stating they would go to a friend), the police (57%), a parent (51%) and a teacher (50%). Girls were more likely than boys to go to a friend, boys were more likely than girls to go to a parent. Children under 14 were more likely than older children to go to a parent or teacher.

33. That going to a friend for help if a child feels at risk is so likely carries a major importance for child protection systems. Children themselves are likely recipients of disclosures of concern about safety from other children. There is a strong case for ensuring that children themselves are aware of what to do if another child
discloses a child protection issue to them, and for child protection systems to be sensitive and accessible for children receiving disclosures of concern from other children.

34. In consultation to secure children’s input to the recent Munro review, those consulted reported that children in care can be scared to relate concerns to their social worker because they fear these will be relayed to their carer, and they fear the consequences of that happening. Although it is contrary to current Regulations, many children in care still report that their visiting and monitoring social worker does not speak to them alone when asking about their welfare and concerns.

BULLYING

35. In the 2010 Monitor survey, 8% of children in the Children’s Rights Director’s remit reported being bullied often or always, and 76% being hardly ever or never bullied. Disabled children reported being more likely to be bullied than children generally.

36. Overall, 79% of reported bullying was teasing or name calling, 33% was bullying by being threatened, and 28% was by being hit or physically hurt.

37. 67% of bullying was reported as being by children in the same age group and 34% by older children or young people.

38. 16% of children in care responding to the 2010 Monitor survey reported being bullied specifically because they were in care.

39. Children were slightly more likely to worry about bullying than they were to be bullied. 12% reported often or always worrying about being bullied (compared with 8% reporting often or always being bullied). This is a consistent finding over successive consultations.

COMPLAINTS SYSTEMS

40. Effective complaints systems are an important protection against abuse. 60% of the children in the 2010 Monitor survey who reported having made a complaint in the past year reported that their complaint was sorted out fairly, but 19% stated that they had not been told the outcome of their complaint. 56% of those in the Children’s Rights Director’s remit reported knowing how to get an advocate (although this is a right for those making a complaint).

STAYING SAFE ON THE INTERNET

41. In a consultation with children aged under 12, children were asked what would keep them safe from dangers on the internet. 27% stated being supervised by adults when using the internet, 23% stated only using safe sites, and 16% stated use of blocks and filters.

42. These younger children also nominated measures they should take themselves to stay safe when accessing the internet: 18% stated not talking to strangers on social networking sites, and 14% stated not giving personal information or putting photographs of themselves on the internet. One in 10 under 12s in this consultation stated that the best way to keep safe from dangers to children on the internet was not to use the internet at all.

43. In another consultation, children and young people advised that children need to be made fully aware of privacy settings on the internet, and of the importance of clearing your internet history to reduce the risks of being tracked.

44. In yet another consultation, on past government proposals for a database of children, children and young people stated two key views on electronic safety. Firstly, that even complex and high technology safeguards will in time be eroded by the carelessness of professional adults using them—such as workers passing on passwords and code keys to others to access information for them. Secondly, children advised that all electronic systems containing information about children were vulnerable to determined and eventually successful hacking by paedophiles.

KEEPING CHILDREN IN CARE SAFE

45. In consultation for a Ministerial Stocktake of care in 2009, children in care reported that out of the then Every Child Matters outcomes for children, councils were doing best at keeping children in care safe, with 53% of children reporting their councils to be doing well or very well at this and 16% reporting their councils as doing poorly or very poorly.

46. Consultation with children in care have identified changing placement to stay with strangers without adequate preparation, information and familiarisation as making children feel unsafe.

47. Consulting children about running away from care has identified running away as sometimes a response to feeling unsafe in a placement, although more often as a wish to be somewhere else or for enjoyment. Once
on the run however, running away is also highly risky, and children are then extremely vulnerable to abuse and worse. Protection of children who have run away from care is a major challenge to the child protection system.

October 2011

Written evidence submitted by Dr Liz Davies, Reader in Child Protection, London Metropolitan University

Summary

— The Children Acts 1989 and 2004 remain the legislative framework for child protection policy and practice in England with Section 47 as the cornerstone. Section 47 is the investigative duty required of local authorities when there is reasonable cause to suspect actual or likely significant harm to a child.

— The 2006 and 2010 editions of the statutory guidance Working Together to Safeguard Children, have undermined the effective implementation of this law by confusing the very different professional tasks of the assessment of children’s needs and the investigation of child abuse.

— Since the mid-90s, policy and practice moved away from proactive child protection. This development led to the demise of child protection systems and structures which had previously enabled children to seek justice and gain effective protection. This shift also led to a reduced focus on the targeting of perpetrators as an integral aspect of multi-agency child protection practice.

— Neither The Victoria Climbié Inquiry (Laming 2003), The Protection of Children in England (Laming 2009) nor The Munro Review of Child Protection (Munro 2011) addressed these issues.

— The recent Multi Agency Safeguarding Hubs (Golden et al 2011), provide an example of good practice and present an innovative return to multi agency joint investigation work.

Biography

Liz Davies is a registered social worker. As a team manager in the 1990s, she exposed child abuse within the care system in the London Borough of Islington and subsequently, as a child protection manager, she developed her specialism in child interview skills and the investigation of organised abuse networks. Since 2002, she has taught social work at London Metropolitan University and has co-authored child protection training manuals and a key text Proactive Child Protection in Social Work (2008). Her PhD thesis (2010) was entitled Protecting children; a critical contribution to policy and practice development. Liz Davies contributes regularly to media coverage of child protection issues, provides consultancy and acts as expert witness for social workers.

1.0 The need to address child abuse and crimes against children

Child abuse occurs within families and this context provided the focus of the Laming and Munro reviews (2009 and 2011). However, there is a vast international child abuse industry that exploits children and includes trafficking for commercial, domestic and sexual exploitation, online abuse, the illegal adoption trade, the illegal organ trade and the trade in abusive images. These are not marginal issues but are addressed by child protection professionals on a regular basis and yet the Laming and Munro reviews were narrow in focus relating only to abuse within the family. There is therefore a risk that models of practice recommended in these reviews omit examination of the intense joint investigative work required to identify and target perpetrators and protect numbers of children in the context of organised crime.

1.1 A critique of current statutory guidance

Working Together to Safeguard Children (2010) states that, “the core assessment is the means by which a Section 47 enquiry is carried out” (5.62). This is not the case. Section 47 involves an investigative process implemented by social workers, police and other agencies to protect children from harm. Following a referral which raises, “suspicion of actual or likely significant harm” to a child, this process must begin immediately and not await the outcome of an initial or core assessment. The process will include decisions about the need for recorded child interviews according to the guidance Achieving Best Evidence in Criminal Proceedings (CJS 2007). It will also include decision making about the need for medical examinations and forensic retrieval of evidence. Legal safeguards to provide immediate protection may be agreed as well as strategies to identify and target alleged or known perpetrators. The process is conducted through professional only strategy meetings and the work demands the highest level of skill from all involved.

1.2 When a Section 47 investigation has been agreed between police and social workers there is no requirement to gain parental or carer consent to child interviews or medical examinations if to do so may place the child...
at risk of harm. The work may be conducted in partnership with families and often results in a family support approach. However, it may involve challenging and confronting parents and carers about the detail of the alleged or known abuse of child/ren and/or intervention to protect the child by removing the alleged or known perpetrator from the family or removing the child from the family. The Section 47 process may also involve large scale, national and international investigations of institutional and organised crime against children. Sometimes the family may be involved as perpetrators or be in collusion with the abuse.

1.3

The current error in Working Together guidance which defines the process as a core assessment confuses two processes. Assessment is relevant to the needs of the child and family within the legislative context of Section 17 (Children Act 1989). In assessment processes parental and carer consent is required for any contact with the child and the work is conducted throughout in partnership with the family. The process is procedural and largely dictated by standardised questionnaires to which timescales apply. However, there can be no time limitation for an investigation of child abuse—the investigation continues until the child is made safe. The impact of this confusion may lead to a delay in immediate intervention to protect a child and a delay in the sharing of information across key agencies. Section 47 is the threshold which determines whether or not certain information may be shared without parental agreement. Also, as Section 47 investigations currently require a core assessment of every child in the family, the resource implications may lead managers to maintain cases wherever possible at the level of Section 17 thus placing children at possible risk.

1.4

Recommendation 13 of the Victoria Climbié Inquiry Report (Laming 2003) suggested the need for a step by step guide on how to manage a case through either a Section 17 (child in need) or a Section 47 (child in need of protection) track as separate and distinct processes. This recommendation was not developed in The Protection of Children in England (Laming 2009) or in The Munro Review of Child Protection (Munro 2011). It was Munro who expressed concerns at where the language of child protection had gone (Munro and Calder 2011). This recommendation was interpreted by police as limiting their role in child protection cases to the investigation of crime resulting in less police involvement in the investigation of significant harm. It is now difficult for social workers to engage police in child protection matters that do not carry out completely and exclusively, any criminal investigation elements in a case of suspected injury or harm to a child’ (Laming 2003:14.57). This recommendation was not developed in the Munro review (2011) was a misnomer as both restated the case for family centred prevention services, and failed to address fundamental protection protocols in relation to children abused both within their families but also as a result of the global industry of child abuse.

Factors affecting the quality of decision making in referral and assessment, and variations across the country

2.0 A decline in police involvement in the investigation of significant harm

Lord Laming recommended that, the Working Together arrangements must be amended to ensure the police carry out completely and exclusively, any criminal investigation elements in a case of suspected injury or harm to a child’ (Laming 2003:14.57). This recommendation was interpreted by police as limiting their role in child protection cases to the investigation of crime resulting in less police involvement in the investigation of significant harm. It is now difficult for social workers to engage police in child protection matters that do not clearly constitute a potential or actual crime. The impact of this change is that social workers are now often isolated in undertaking single agency investigations whereas in the past this would have been a joint process from the point of referral. The close working that there used to be between police child protection officers and social work specialists in protecting children has therefore been minimised. An exception is seen in the MASH model where police are co-located with social workers and health professionals in intake teams.

2.1 Impact of the changed police role on joint investigation and joint investigative interview training

The Achieving Best Evidence guidance requires a child-centred interview to be conducted collaboratively (CJS 2010:2.22). However, there has also been a reduction in the provision and availability of joint child protection training at advanced level between police and social workers in Section 47 investigation and investigative interviewing of children. With few social workers now trained in these skills, it is not uncommon for police to conduct child interviews without social work involvement. The Chair of the House of Commons Children, Schools and Families Committee, Barry Sheerman MP commented on the author’s evidence that, ‘it was important to get on record that you are saying that something quite dramatic changed in terms of how the police pursued the possibility of a child being at risk’ (2009:76).

2.2

It is important to note that government commissioned research, cited in Working Together (DfE 2010:112), omitted to include this aspect of child protection training (Carpenter 2009). The author was informed that this was because it did not fall within the remit of Local Safeguarding Children Board responsibilities as it involved just two agencies—police and social work. Working Together (2010:127) does specify Group 4 level training in Section 47 enquiries including investigative interviewing and yet this important aspect of training is not addressed by Laming (2009) or Munro (2011). Joint training should be available to all police working with children, not solely those in the Child Abuse Investigation teams. It is of significance that neither Lisa Arthurworrey (social worker for Victoria Climbié) nor Maria Ward (social worker for Peter Connolly) had...
2.3 The abolition of the child protection register removed an effective child protection protocol

The Child Protection Register was abolished in April 2008. The word Register was airbrushed out of policy and prior to that date the protocol had been severely undermined as local authorities reduced the numbers of children whose names were on the register in order to facilitate their compliance with targets. The author’s professional experience of the Child Protection Register is that it was effective in identifying children at high risk of harm and in focusing multi-agency professional resources into protecting the child/ren. It also provided an alarm to the emergency services and triggered a specialist response. A ministerial response to a parliamentary question clarified that the Register had been abolished on the basis of no research findings even though it had been developed from serious case review recommendations and it was known that very few children who died from abuse had been the subject of registration (Dhanda 2007, Reder and Duncan 2001 and Brandon 2009).

2.4 Munro’s dismissal of the need for a national “signposting” service

It was a remit of the Munro review to look at the need for a national signposting service and to consider the potential value of having a national means of providing a quick and reliable way of identifying whether a child or young person is, or has been, the subject of a child protection plan (Munro, 2011:4.23). As if in denial that the Register had existed for over twenty years, Munro did not mention it at all or consider multi-agency experience of the functioning of the Register to inform her views. Munro referred to there being no compelling case for a national system of identifying whether or not a child is or has been the subject of a child protection plan. She stated that most hospitals and GP surgeries now had, “some kind of system for flagging a child’s electronic record to indicate that he or she is the subject of a child protection plan” (Munro, 2011:149). However, a survey of hospitals by Rose (2009) suggests that this statement is unfounded. Also, Munro referred to research (Brandon et al. 2010) that found that 72% of children who were the subject of serious case reviews between 2007–09 had, “never been the subject of a plan” concluding that, “it has limited value as a predictive factor” (Munro, 2011:150). The important significance of these findings, which echo those of Reder and Duncan (1999), is that intervention processes failed those children who did not receive the benefit of a multi-agency protection plan. These children were either unknown to agencies or had been defined as children in need rather than children in need of protection.

2.5

Where child protection planning is in place for children they do in general gain effective protection. It is therefore important to have systems which draw professional attention to this cohort of children and the Register was indeed that system. Munro recommended local authorities providing 24 hour access to concerned ‘others’ who could phone children’s services and make checks (Munro 2011 App.C). However, the register was never dependent on an individual becoming concerned as the alert went to the emergency services routinely without the need for a request. A National Child Protection Register would protect children more effectively than local registers and should include children who are missing. Such a register would be a proportionate response to high risk situations and would assist in the task of keeping children safe from harm across authority boundaries.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

3.0

The decision as to whether or not to remove a child from their parents is more likely to be flawed if there is no joint investigative process informing that multi-agency decision. Assessment processes do not adequately inform care proceedings or the decision as to whether to proceed in the direction of legal safeguards. The lack of investigative work leads to faulty decision-making. Children will be removed from families without good reason and will not be removed when they need to be separated from their families as a protection from harm. This fact was all too evident in the Peter Connolly case.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of children

4.0

The promotion of the privatisation of child protection services is of great concern to the author. Protecting children is a highly politicised activity situated at the interface between the power of the state and that of the family and is a measure of societal attitudes towards the rights of children to be protected from all forms of abuse. Child abusers have their own agendas and also promote their interests through political processes. There is much contemporary pressure and action towards outsourcing assessments and even suggestion of outsourcing
statutory child protection (Garboden 2011). However, there is a strong argument to retain child protection services within Local Authority democratic control in order to ensure the public scrutiny of service provision, remove the profit motive and self-interest from the provision of services to abused, exploited and vulnerable children and provide strong opposition to those abusing children. Current critique of the extent of bureaucracy and managerialism in social work must be situated in the context of imposed central government demand on local authorities and not used to remove services from a democratic system where political processes can protect children’s rights and the rights of professionals to promote and implement good practice.

RECOMMENDATIONS

5.0

— The Child Protection Register to be reinstated and form the basis of a National Child Protection Register which would include details of missing children.

— Working Together to be amended in order to clarify that Section 47 joint investigation is a process which is distinct from a social work assessment of the child’s needs.

— The police to resume their role in child protection in the joint investigation of significant harm.

— The provision of Section 47 investigation and investigative interviewing training for police and social workers to be a requirement of the LSCBs.

— The development and implementation of the MASH multi agency child protection system to be promoted throughout the UK.

— Child protection services to remain situated within Local Authorities.

REFERENCES

6.0


Written evidence submitted by Centre for Family Policy and Child Welfare, Bristol University

THE REUNIFICATION OF LOOKED AFTER CHILDREN WITH THEIR PARENTS:
PATTERNS, INTERVENTIONS AND OUTCOMES

Reunification in the UK has for long suffered from neglect in policy, practice and research. This study aimed to fill some of these research gaps by means of a two-year follow-up of a sample of 180 looked after children who were aged 0 to 14 when they returned to their parent/s during a one year index period. The sample was drawn from six local authorities and data collection was by means of case file reviews, followed by interviews with a sub-sample of 34 parents, 19 children and 22 social workers. At the point of the returns 30% of the children in the study were under 5, 21% 5–10 and half (49%) aged 10–14.

Key Findings

The Children in Care

Half (53%) of the children entered care because of abuse or neglect and a quarter (28%) because of the children’s behaviour. Before returning home, the majority of the children were voluntarily accommodated (60%). By the time of the return, the remainder were subject to Interim or Care Orders (36%) or Supervision Orders (4%). As expected, children subject to court orders were significantly younger than those voluntarily accommodated.

Most children returned home from foster (71%) or kinship care (8%), but 13% did so from residential units or schools whilst a small group (8%) returned to the community with their parent/s from mother and baby foster placements or residential family assessment centres. Some of the parents interviewed were dissatisfied with residential care since their children’s behaviour had rarely improved and had sometimes worsened there; whilst 9% of the children were abused in care (by caregivers or other children), which could lead parents to remove children from placement, judging that care was unsafe.

Initial Care Plans

There were four distinct groups of children in terms of the relationship between their initial care plans and the time it took before they returned home. At one extreme were young people (6% of the sample) who absconded home or were removed soon after placement by dissatisfied parents before any plan had been made for them? A second group of children (41%) whose initial plan was “return home” were mostly accommodated adolescents who returned within an average of six months. In contrast, younger children whose initial plan was “time-limited assessment” (45%) were generally on Care Orders, considered at risk and took twice this long to get home. A final small group (8%) returned to their parents after an average of three years in care because the permanence plans made for them had not been fulfilled. The first two groups (like the others) had adverse backgrounds but they had also experienced a high number of previous returns home, yet monitoring and services for them were relatively sparse.

Assessment and Intervention

43% of the children returned to a parent without any in-depth assessment of their situation (and a third were never assessed before or during the return). Assessment was linked to service provision and to return stability. More specifically multi-agency assessments—which often led to services—were linked to the resolution of the problems that had led to care and multi-agency work to return stability.

Specialist professionals saw a third (34%) of the children and almost half (49%) of the parents before the children returned home, but in other cases (20% of parents and 9% of children) referrals had been made to mental health or other professionals but did not eventuate, because the service was unavailable or parents did not keep appointments. In addition, social workers conducted direct work with a fifth of the parents (22%) and children (19%).

Conditions for the return were set in just over a third of cases (37%) and were mostly set when children were younger, the family situation had been assessed and when the return took place during care proceedings. Where no work was provided for any family member (23% of cases), problems tended to persist into the return.

The Children’s Pathways Home

The Decision for Return

For most children (61%), the decision to return them to a parent had been made (and recorded) within six months of them being in care. The remainder waited a year (10%) or more (11%) before the return decision was made.

53 Excluding children who returned within six weeks of entering care unless they re-entered care in that year.
Planning and Pressures for Return

The returns had been officially planned in three quarters (73%) of cases. Whilst improvements in the family situation, or more rarely the child’s behaviour, accounted for almost half (48%) of the primary reasons for the planned returns, pressures from the parent, child, placement or the court accounted for another quarter (28%).

Over a quarter (27%) of the children returned home even though no official plan for reunion had been made. They returned to a parent because: they had absconded there; been removed from voluntary accommodation by their parents; their placement had broken down or the social worker had agreed under pressure to a return home. Moreover, pressures for reunification were evident in ¾ of all the cases. When children pressed for reunification or their return was accelerated because of placement or other problems (often connected with difficult child behaviours and sometimes with absconding home) there were more return breakdowns.

Reservations about the Returns

Professionals expressed concerns about as many as a third (35%) of the returns (including social work reservations in 26% of cases). In the interviews parents often said that they too had harboured doubts about the wisdom of return at that time and about their ability to cope, whilst children had been worried about rejection, abuse and exposure to their parents’ problems when they returned.

Preparation for the Returns and Problem Resolution

Specific preparations for the children’s returns were made in a third (36%) of cases whilst only a third of the children (aged 4+) were recorded as having been consulted about the timing and manner of the return, and some told us that they had gone home too quickly without adequate preparation. When adequate preparation for return had been made, reunification was significantly less vulnerable to disruption. In addition, when caregivers (mostly foster carers) had developed an exceptionally supportive relationship with the parents (a fifth of cases), there were significantly fewer return disruptions. In such placements, caregivers worked closely with the parents and/or children to bring about change, remaining available and at times involved after children returned home.

Many (57%) of the returns were supported with a package of services (although in a quarter no services had been provided for the parents or children whilst the child was in care). In the researchers’ view, in only a quarter of the cases (26%) had all the problems for the children and their parents been addressed prior to reunion? Often, issues which had the potential to jeopardise the success of the returns, remained unresolved or hidden (especially drug or alcohol problems or continuing relationships with violent partners).

The Returns

Change and Continuity

Two-thirds of the children (64%) returned to the same parents (or parent figures) they had lived with previously, a quarter (26%) returned to a household which a parent or partner had left or joined while they were away, whilst 10% returned to a different parent. Other siblings had also left or joined these households so that, in total, only half of the children (52%) did not experience any changes in the membership of the household to which they returned. Returning with siblings was related to return stability (as in other kinds of placement).

The likelihood of return stability was significantly higher when children moved to the other parent (who generally had fewer problems than the parent(s) from whom the child entered care) or when there was a change in household composition (which could mean that a new more positive partner had joined the family or a former negative partner had left). So, change was often positive.

The Children’s Experiences

Although most children returned to the same school, some saw a change of school as an opportunity for a fresh start. Just under half of the children interviewed had not been able to maintain contact with all their friends whilst they were in placement and the same proportion lacked strong friendship networks during the returns. A third confided in no-one once they had returned home, whilst a few felt like outsiders in their own families.

Returning to Parental Difficulties

Three-quarters of the children (77%) were returned to parents who had previously abused or neglected them. Four fifths (82%) went to parents with a history of domestic violence, drug or alcohol misuse or exposure to inappropriate sexual activity54 and three-fifths (60%) to a parent with mental health problems. Ten percent of the mothers (10%) and five percent (5%) of the fathers had learning difficulties.

54 Inappropriate sexual activity included prostitution, open use of pornography or a high number of changes of sexual partner.
Parental ambivalence (relevant to 42% of the children) and previous failed returns (which had occurred for 38%) were significantly related to return disruption. This highlights the need for proactive intervention to tackle children’s and parents’ difficulties before any renewed attempt at return.

**Children’s Services Support for the Returns**

Support was provided by Children’s Services to the majority of the children’s families (84%) during the return. This included financial or material support (41% of the families), assistance from Family Support Workers (41%), respite care (24%) and attendance at play-schemes or other activity groups (12%), albeit that such help was sometimes short-term. Over half of the children under school age received assistance to attend childminders or day nursery. Social workers also provided direct work to one in five of the children and parents.

**Other Agency Services**

Nearly half of the parents (46%) and of the children (aged 4 +) (43%) were also provided with specialist support by other agencies, such as mental health or youth offending teams, local family centres or health professionals.

**The Impact of Services**

Families with children subject to Care or Supervision Orders received the best support with over three-quarters (77%) rated by the researchers as good or very good compared with under half (45%) of the support provided when children had been accommodated. Returns were significantly more stable when additional services such as day care or specialist help for the parent or child were provided during the return. The social work task in arranging reunification was often “huge” and depended on team manager support, particularly when cases required intensive services. However, in practice reunification was sometimes viewed as an area where resource savings could be made. Highly competent social work (that is consistent and purposeful work and monitoring of the child and parent/s) was significantly related to return stability. These findings emphasise that appropriate specialist services and highly skilled relationship-based social work can and do make a difference to return outcomes.

**Gaps in Services**

There were many gaps in the services to support return, most notably insufficient assistance with behaviour management (especially in dealing with behaviourally difficult adolescents) and the lack of help for parents with substance misuse problems. Whilst almost half (46%) of the mothers and a fifth (17%) of the fathers to whom the children returned had known drug or alcohol problems, only 5% were provided with treatment to help them address their substance misuse. Another gap was evident where the policy of providers (particularly CAMHS) was not to offer a service until the child was settled (which in some cases never happened).

In all, almost a fifth of the parents (17%) and two-fifths of the children (40%) did not receive any support at all during the return—either from Children’s Services or a specialist agency—and as a result, some parents were caring for very disruptive or emotionally troubled children without any assistance. The full extent of many difficulties did not become apparent until some time into the return or after it had disrupted.

**Support from Schools**

The local education authority provided educational assistance to over half of the school-age children. Some schools provided considerable support to children (and sometimes parents) and the interviews suggested that this could be important to the success of the returns. During return 42% of the children attended school poorly whilst 20% were excluded from school and both of these issues were significantly related to return disruption.

**Informal Support**

Informal support during the returns could be critical and was provided to over half of the children’s families by friends, family or local organisations. Good informal support for parents and/or adolescents was significantly related to return stability, whereas social isolation was highly associated with return disruption. When parents or young people lack adequate support from their own networks, attempts to initiate a network of informal support may be needed or more professional help and support in compensation.

**Monitoring and Regulation during Returns**

Other agency professionals (eg health visitors or nursery staff) provided supervision of the child in three-fifths (61%) of cases and such monitoring was associated with return stability. Setting conditions before or during return was also related to return stability but was rarely undertaken with the parents of adolescents. Returns were less likely to break down when the return took place during care proceedings, was subject to multi-agency supervision, the children were on the Child Protection Register or had been looked after from birth. These were the returns which were closely monitored and resourced to try to ensure that the home situation improved.
Nonetheless, parents often disliked being monitored or assessed, feeling that professionals, especially social workers, were “digging the dirt” on them and sometimes that control was provided without any accompanying encouragement. Indeed, a small number of the children were rarely or never seen during the return, partly because of parental/child resistance. A number of the parents were extremely difficult to help, with some attempting to conceal their substance misuse problems or violent partners from social workers. Forming constructive working relationships with parents in such situations was far from easy but when this was achieved parents were appreciative. Firmness about parenting standards needed to be combined with empathy.

Case Closure

Almost half (48%) of the cases had been closed before the end of the two-year follow-up period—a fifth within six months. Many (47%) had been closed despite ongoing concerns and these returns had an increased chance of breaking down. Almost half of the closed cases had to be re-opened, whilst for a few families a social worker was never allocated or never visited during the return.

The Children’s Progress at Home

Recurrence of Parental Difficulties, especially Substance Misuse

Once the children went home, there was considerable improvement in some areas. Domestic violence, which had featured in two-thirds (67%) of families before the children entered care, was reported in under a fifth (16%) during the two-year follow-up period, probably because mothers had separated from violent partners whilst substance misuse, which had been an issue in 59% of the families, was now evident in just under a third.

However, the difficulty faced by professionals in bringing about change in parental behaviours is shown by the recurrence rates of these issues. Whilst domestic violence re-appeared in only a fifth of cases, alcohol misuse recurred in more than half the cases (51%) and drugs misuse in 42%. Other issues which recurred frequently were social isolation (74%), financial problems (59%), poor parenting skills (57%), multiple parental partners or house moves (53%), parental anti-social behaviour (43%) and poor home conditions (42%), despite a drop in the overall prevalence rates of these behaviours.

In addition, all of these issues were significantly more likely to occur where a parent was misusing drugs or alcohol. In addition, children of substance misusing parents (78%) were much more likely be abused or neglected than children of parents without substance misuse problems (29%).

Abuse and Neglect

Almost half of the children (46%) were abused or neglected during the return—exactly half the number who were thought to have been maltreated prior to entering care (91%). Neglect (33%), emotional abuse (25%) and physical abuse (21%) were particularly likely to recur, unlike sexual abuse (9%), where the perpetrator had often left the household. New occurrences of maltreatment were relatively rare, except in relation to physical abuse. Statistical analysis revealed that poor parenting skills was the greatest predictor of child maltreatment during the return, followed by drug or alcohol misuse.

After concerns about maltreatment had been raised, 17% of the children were immediately taken back into care. However, 41% of them remained at home without adequate safeguards, whilst 16% of the children stayed at home despite ongoing maltreatment. When babies or children under five were at risk or had been physically abused, great care was usually taken to assess the parents and monitor returns and swift action was taken if necessary to remove the children. However, practice was much less consistent as children became even a little older. Delays in returning children to care sometimes occurred because there was thought to be insufficient evidence to initiate care proceedings.

Only a quarter (28%) of the children’s names were on the Child Protection Register during the return (including less than a third of those who had suffered abuse). The children who were least likely to be monitored adequately were those where there had been no assessment or who were not on the Register.

Most forms of difficult behaviour were more likely to recur during the return than be resolved. For example, almost half of the children exhibited conduct problems, under-achievement or non-attendance at school or nursery during the return. Many parents struggled to cope with these behaviours and concerns about the parents’ care of 69% of the children were reported to Children’s Services, mainly by professionals but also by relatives and neighbours.

Nonetheless, most children (57%) appeared to be close to a parent, although a tenth (11%) were close to only one parent/figure and not the other, and worryingly a third (32%) were close to neither. A considerable number of the young people said in interview that they found things difficult at home (12/16), felt sad, confused or angry or missed their former placement. Seven young people were depressed or felt lonely and abandoned and two wanted to be in care.
THE OUTCOMES OF THE RETURNS

By the end of the two-year follow-up period almost half (47%) of the returns had broken down.

Although most (59%) of the continuing returns were rated as of good quality (or “successful”) for the child, a quarter (24%) were borderline (where it was finely balanced as to whether or not the child would have been better off in care) and 12% were of poor quality (or “unsuccessful”). Given this situation, there is a need for closer monitoring of return decisions and return progress within local authorities.

AFTER THE RETURNS ENDED

A third of the disrupted returns failed within three months, a further third after 4–9 months, and the final third before the end of the two-year follow-up. The 84 disrupted returns had lasted an average of seven and a half months. The parents themselves initiated the end of almost half of the returns (43%), whilst Children’s Services (28%) or the court (5%) intervened to protect the children a third of the time. Few children (17%) were able to return to the placement they had been in before the return. Almost two thirds (62%) of the children with disrupted returns were reunified again, once or more during the remainder of the follow-up period and half of these returns also failed.

ISSUES

LEGAL STATUS AND AGE

Children who returned home on a Supervision or Care Order (or who were on the Child Protection Register) were significantly less likely to experience return breakdown as compared with those who had been voluntarily accommodated. Part of the explanation is that children on orders were younger, received more (and better) support, were more often set conditions and were subject to closer monitoring. However, age was only part of the picture, since for both the younger and the older children, return to their parents on court orders was significantly associated with lower levels of return disruption, compared to when no order was in place.

Being over the age of 10 was strongly associated with return disruption, as in other kinds of placement and in previous research on reunification. A range of adolescent behaviours prior to the return were significantly linked to disruption (substance misuse, offending, truancy, school exclusion, conflict with parents). The proportion of young people who showed improved behaviour or lessening of their difficulties as a result of their stay in care was low.

The interviews revealed the difficulties of bringing about change in such young people. Nonetheless, there were promising examples of good practice, where the placements in care had included interventions for the young people aimed at helping them to change their behaviour, (and assistance for parents with behaviour management) and where adolescents and their parents were able to access a strong network of support after return, which could include respite care and support for the young people from a mentor, teacher or a parent’s partner. After-care services from the placement also helped to maintain some of these returns.

PARENTS’ VIEWS OF THE HELP THEY NEED

When we asked parents what help they had needed they prioritised: treatment for substance misuse combined with clarity about the consequences of their taking no action about their addiction; help with behaviour management and earlier recognition of their difficulties with their children; help to build up their self-confidence as parents; to be listened to and respected; monitoring of their progress that is combined with emotional warmth; direct help for children (such as mental health assistance, anger management and mentoring), respite care and the opportunity to talk to other parents in the same situation.

FACTORS THAT RELATED TO RETURN OUTCOMES

Prior Parenting, Abuse and Hyperactivity

A number of the factors that significantly related to return outcomes have already been mentioned. In addition, previous physical abuse of the child and evidence that parenting skills were poor prior to the return were both significantly associated with return disruption. Prior sexual abuse of the child was related to poor quality returns (probably because of the link between sexual abuse and poor parenting and with later emotional and behavioural difficulties). For children under the age of 10, previous hyperactive behaviour was also strongly associated with return breakdown.

The combination of factors which best predicted return stability

When we analysed the factors by age, we found that in order of influence for younger children the most influential variables in relation to return stability were: parental ability to cope after return, the child having entered care with siblings, receiving financial and practical support, being on a court order and change of home. But for adolescents the most influential variables were in order of influence: a change of home, good informal support and the local authority the child lived in (see next section).

56% of the accommodated children were over the age of 10 at return compared with 34% of those on court orders.
DIFFERENT LOCAL AUTHORITY POLICIES AND PRACTICE

There was considerable variation in the priority and resources given to reunification by the different authorities in the study and the return disruption rates in our local authorities varied widely\(^{56}\) from a high of 75% of returns to a low of 32%; similarly, success (or quality) rates varied from a high of 64% to a low of 10%. It appears then that different practices in different authorities lead to different outcomes. Local authority variations in practice were particularly apparent in relation to the outcomes for the older children, where practice appears to be especially variable across authorities. There is therefore a need for authorities to develop clearer policies and procedures to guide reunification practice for all children, whether they are accommodated or on Care Orders.

HIGHLY UNSATISFACTORY RETURNS

We considered that 20 of the returns of the children who remained at home at follow-up were borderline (where it was finely balanced whether the child was better off at home despite the serious limitations there or should have been in care), whilst 10 (6%) were of very poor quality. In the latter group, children were living with parents with serious mental health problems or substance misuse difficulties (sometimes combined with domestic violence) who were often also physically or emotionally abusing their children, such that it appeared to be damaging to their welfare.

OSCILLATION

Two thirds (64%) of the children in the study had experienced one or more failed returns over the time we followed their histories, including a third (35%) with two or more. This latter third of children we termed “oscillators”. One such child had endured 13 return breakdowns by the age of 16. The social workers and children in the interviews commented on the severe negative impact on children of oscillating between home and care. More needed to be done in some cases to prevent a continuing pattern of oscillation between home and care eg through ensuring that reviews pick up patterns of oscillation so that more decisive intervention can be planned.

IMPLICATIONS FOR POLICY

— Returns subject to scrutiny by the courts had high levels of assessment, monitoring and service and were more likely to succeed. A more structured approach to returns for accommodated children, combined with parenting support and behaviour management is needed.

— There is a need for more targeted work with young people with behavioural and emotional problems during their placements and also more consistency in arranging tailored support packages for young people and their parents to help to make these returns work. The use of respite care and marshalling informal support for parents and young people might play an important part in maintaining some of these placements.

— It might be useful if individual local authorities reviewed their reunification practice, given the variation in success rates across our authorities, especially with accommodated children. The value of skilled and purposeful social work reunification practice requires recognition within authorities.

— Assessment and case planning need to specify from the outset what needs to change, over what timescales (having regard to children’s developmental needs) before return is possible and how this is to be supported and monitored. Using written contracts which agree clear goals with parents and which are regularly reviewed can be useful, alongside the provision of tailored services addressing parents’ and children’s difficulties.

— More focus is needed on preparation for return. There are likely to be benefits if foster carers and residential workers could be more involved in preparing children and in providing follow-up support to them and to their parents after reunification. This is an area of practice that might usefully be further developed.

— Reunification practice in cases where parents misuse alcohol or drugs needs to be reviewed, to introduce clear expectations that parents will be required to address their substance misuse before children are returned to them and that their use of substances will be closely monitored and reviewed before and during return. In addition, more access to treatment for parental substance misuse problems is required alongside more training for practitioners in how to work with substance misusing parents—substance misuse was related to higher levels of abuse and neglect, poor parenting and domestic violence during return.

— Standards during the return need to be agreed and regularly reviewed with action being taken when children’s quality of life at home becomes unsatisfactory or when they oscillate between home and care. Not taking such action involves considerable ‘costs’ to the well-being and future prospects of the children concerned.

\(^{56}\) Excluding the two local authorities with small numbers of cases.
Ev w60 Education Committee: Evidence

REFERENCE


Written evidence submitted by Children England

1. Children England is the leading membership organisation for the children, young people and families’ voluntary sector and the Department for Education’s overarching strategic partner. With member organisations working in all parts of the country ranging from small local groups to the largest household names in children’s charities, Children England is in a unique position to use the collective voice of the voluntary sector to achieve positive change for children. Children England provides capacity building, support and information to its members and the wide range of voluntary sector organisations working with children, young people and families. It does this by building active networks, promoting good practice, stimulating policy debate and ensuring that the issues that matter most to its members are taken up with decision makers.

2. Children England is committed to working alongside its members in the creation of a society where children and young people are valued, protected and listened to, their rights are realised and their families supported.

3. Real thought has to go into the causes of children being at risk in families. Engagement with families under stress has to happen early on. The support given should be holistic and tailored to each family, not every family does well in parenting groups for instance, especially when they already feel that they are bad parents. When people are in debt, have housing and relationship problems and their children have behavioral difficulties they need support and encouragement to build both their own and their children’s self esteem.

4. What has been missing all too often is this level of support which is not provided by social services until families are in deep crisis. A problem that has been getting worse as local authorities, coping with sharp budget reductions, have often cut back on all but crisis services. Voluntary groups work in this way to prevent families reaching crisis, by gaining their trust, they are then able to be honest about their parenting and by providing access to funding, outreach parenting support, therapeutic groups for them and groups for their children that address behaviour issues and build self esteem, families become happier, there is an improvement in safeguarding practice and children have a better chance to reach their full potential.

5. Although the government has recognised the cost effective nature of this work and understands that preventative work is an essential part of a properly balanced safeguarding system, it has not provided early intervention budgets, with the new Early Intervention Grant to local authorities worth considerably less than the separate funding streams that it replaced. Our members have already reported, in Children England’s survey in March 2011, that early intervention services are being cut, with limited financial resources prioritized for crisis services. As such, while we welcome the emphasis given to early help in the recent Munro Review, we are concerned about local authorities’ ability to meet the proposed new early help duty given these cuts.

6. However, social services departments struggling with limited resources are not a new phenomenon. Our members have identified that the move to safeguarding children introduced a broader range of responsibilities to an already overworked group of professionals. No one would argue against the principal of safeguarding children in this broader sense, but the responsibilities have come without the requisite resources. The consequence of this on the ground is that the same small group of over stretched professionals have yet more to address and this comes at a cost. Many very experienced social workers are leaving the profession blaming this widening of responsibility as well as the massive increase in bureaucracy/form filling and the constant preparation for inspection.

7. Aside from resource problems, our members have highlighted a number of specific barriers to identification and the provision of early help. Firstly, children and young people need more guarantees from people in authority when they disclose abuse. Far too many children are still being put off from reporting abuse due to no guarantees that they won’t be separated from siblings or sent back to their abuser due to lack of evidence or not meeting the threshold. In addition many workers are not confident in assessing the evidence they receive from children in relation to that provided by adults. There remains a tendency to de-value their views and experiences. The extension of advocacy services would assist with giving children the confidence, access to dedicated support and a voice independent of those having to assess cases and ration resources.

8. Secondly, safeguarding staff often do not understand the needs of children and parents who have physical and mental disabilities which impede communication. The training available to those safeguarding children often does not include any input on children with complex needs, communication difficulties and particularly autism. This is vital for staff in education, health and voluntary sector settings as well as in social care.
9. Finally, there are issues with supporting the youngest children. During consultation, one of our members, a Family Support Worker for a children’s charity, said:

“Children over two and under five can all too easily disappear from services. It is rare for a health visitor to consistently visit a three or four year old due to massive case loads and lack of time. There is also less of an expectation on a parent to attend clinic with a three or four years old. Some of my clients have not seen their Health Visitor for over two years, even though they have small children”.

Factors affecting the quality of decision-making in referral and assessment, and variations across the country

10. Our members have raised a number of issues relating to referrals. Firstly, there is an increasing tendency not to accept referrals concerning teenage children and particularly older boys. This is in part an issue of thresholds but also reflects a lack of understanding of the safeguarding needs of these groups and how they may present themselves. The situation is more acute with refugee and asylum seeking young people and those from some BME communities where cultural misunderstandings and confusions compound the difficulties of timely and sensitive assessment of need and appropriate interventions. Ongoing training, regularly updated to take account of the changing nature of abuse and exploitation, including on-line bullying and grooming etc. needs to be in place to ensure staff in all agencies are confident in serving the needs of these young people.

11. Secondly, many organisations have said that they have no idea what happens after they have made a referral and find it difficult to get a response from the agency they made the referral to.

“There are delays in action when referrals are made to Social services when there is concern about a child and often after a home visit has been made, there appears to be no follow up procedure. This often results in apathy about referral.” Manager of a Children’s centre.

12. Thirdly, the huge variation in local arrangements can be extremely confusing for service providers who work across a number of local authority areas. Not only is the inconsistency inefficient but it also hinders the development of an early offer.

13. We would like to highlight excellent practice in two areas. Kirklees Council has worked with its VCS to develop a handbook “Safe and Sound” which assists the sector in understanding referral routes and thresholds for intervention and how the sector can work in partnership with the authority to keep children and young people safe.

14. The Solihull Model for Multi Agency Support of Children, Young People and Their Families, known as LINCS (Local Integrated Needs-led Coordinated Support) has enable VCS organisations to initiate CAFs. The LINC will then take responsibility for identifying an appropriate Lead Professional to take the CAF process forward, thus engaging the sector whilst recognising their capacity issues. Also the sector can have the confidence to initiate a CAF knowing there is a clear and established system for allocating to an LP and that they will not be morally guilt tripped into taking on the role due to a lack of alternative arrangements.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

15. Many of our members tell us that they feel local authorities and other agencies have too high thresholds when it comes to taking action on a referral. Feedback included:

16. The pressure on local authorities to cope with referrals means that the threshold for referral has been raised. The number of times authorities in whose area abuse has occurred attempt to pass the case to the authority in which the child’s parents live has increased exponentially.

17. In the past children placed under the provisions of section 20 of the Children Act meant that they were visited by social workers and were the subjects of regular reviews etc. In efforts to reduce the number of “children looked after” some authorities now list these children as being cared for under Section 17 of the Act removing the safeguard of regular social work visits. This has reduced safeguarding and is another example of corner cutting by people under intense pressure to meet demand.

18. Local Authorities and other agencies not being in agreement about what constitutes abuse/neglect often results in no action taking place, again thresholds come into play.

19. The increasing thresholds required for social work intervention have meant that voluntary organisations are increasingly being asked to deal with more complex and difficult cases in community settings, but without additional resources or access to higher levels of training.

20. VCS organisations which work across many authorities report widely varying practice in the acceptance of referrals and subsequent case management for children and young people with very similar needs and circumstances.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

21. There is a need to encourage and promote stability within the childcare system as a whole, but this is especially important within safeguarding. The relationships of trust and the understanding of protocols,
accountability chains and agreed multi-agency referral procedures need time to bed in, be owned and used reliably by all those caring for children and young people in an area. As such, the Committee should be mindful of the extent to which its recommendations would lead to increased churn.

22. There are several causes of the current instability.

23. The well documented levels of social work staff turnover create instability in continuity of recording and evidence gathering; there can be several social workers assigned to a case during quite intense CP Procedures.

24. Many areas of work which impact on the quality and support for safeguarding are funded through time limited funding streams. The longevity of projects in both the statutory and voluntary sector that carry out excellent work and make positive change are often threatened through lack of funding, and lose good staff due to this insecurity.

25. In the last five years many organisations in the voluntary sector have experienced real difficulties because of the development of a commissioning environment which is financially and target driven. Most contracts are short term, in spite of the recommendations within the Compact. Often the pressure to cut costs leads to insufficient money to pay for robust recruitment and supervision, training or the support that makes for a high quality professional child-centred service, which are by their nature often expensive in comparison with other services.

26. In addition, the introduction of competitive drivers has made a virtue out of innovation and radical change, when in fact what many staff and service users tell us they need is continuity and consolidation of their services, allied with incremental improvement.

27. The introduction of Children’s Trusts (and the subsequent removal of their statutory basis) and LSCB’s plus the many changes to NHS structures (with more to come) has led to a protracted period of restructuring of local services and changes of personnel. This has disrupted long standing relationships and has to some degree destabilised the way child care services are provided. Time is needed for all sectors and agencies to have confidence in the new systems and their roles within them. Children England and many of our members work alongside the Children’s Workforce Development Council, General Social Care Council and Skills for Care. We have seen how continual restructuring and change challenges the commitment, knowledge and expertise of individuals and teams.

28. The Committee should also be aware that there are specific issues with the child protection policies and practice of small voluntary and community sector organisations. Children England has in the past few years undertaken research work with members and the small organisations it supports directly that shows both a worrying continued lack of awareness, both about safeguarding practice and its importance. In Under the Radar (2007), a survey of 108 small organisations we found that only 38% of organisations reported having attended safeguarding training. That number dropped to 14% for organisations with no paid staff. In the same report, only 24% of respondents wanted more access to safeguarding training—the least desired training from the seven options they had to choose from. In a follow up survey, carried out in late 2008, we asked how aware organisations were of the new Independent Safeguarding Authority and the vetting and barring scheme. 33.7% of small organisations had never heard of it and only 45% knew it has to do with safer recruitment. Just 18% were aware of the start date for the scheme.

29. During consultation events, our members identified that a key reason for this lack of awareness was that VCS organisations are often excluded from joint working and multi-agency training. Where training is available, VCS organisations have to pay for it whereas statutory agencies receive it free. Where multi-agency training has been prioritised it is paying dividends not only in improving practice but also in building the relationships of trust and respect which must underpin any effective safeguarding system. Our members report increased understanding of the constraints and context within which the wider system must operate and feel more confident in playing a supportive and appropriate role within it.

30. Support is also available through Safe Network (http://www.safenetwork.org.uk) which Children England delivers in partnership with the NSPCC and the Child Accident Prevention Trust, funded by the Department for Education. The programme is focussed entirely on raising the child protection awareness and confidence for volunteers and staff in some of the smallest community and activist groups in the country, reaching those who may have never even considered their potential role in helping to protect children before. With Government ambitions to see more and more members of the community engaged in increasing levels of informal and unregulated activity with children and families in their communities, practical and direct engagement with them about what they can and should do, and how to develop their skills and judgements, where a child may be in danger, will be critical.

31. The importance of developing the children’s workforce was also rightly recognised by the Munro Review and it is vital that her recommendations are properly considered and resourced in the round—not only for the social work professionals and managers directly affected by child protection and social work reform, but for all agencies and professionals responsible for working with children and in partnership with local authority teams. Ongoing professional development is absolutely essential if these reforms, which rely on well-informed professional judgment, are to be a success. Unfortunately, funding for the Children’s Workforce Development Council as a Non-Departmental Public Body comes to an end in March 2012, with only £44 million allocated in this final year for the Social Work Improvement Fund. The situation is particularly acute for VCS
organisations, which in most cases, in the absence of external support, are unlikely to have the necessary resources to internally upskill their own staff.

October 2011

Written evidence submitted by The Consortium of Expert Witnesses to the Family Courts

CHILD PROTECTION INQUIRY

1. The Consortium of Expert Witnesses to the Family Courts is comprised of 500 experienced professionals who prepare Medico-Legal reports. We are clinicians from a range of disciplines, including paediatricians, radiologists and other medical and surgical specialists, forensic physicians, adult psychiatrists, including forensic and perinatal psychiatrists, child and adolescent psychiatrists, psycho-analysts, clinical psychologists, forensic psychologists, clinical neuropsychologists, educational psychologists, child and adolescent psychotherapists, adult psychotherapists and social workers. We work throughout England and Wales. We provide expert input to Family Court proceedings, both public law child care and private law proceedings and to Local Authority pre-proceedings cases.

2. Expert witnesses provide a second tier to child protection work, in that our assessments regularly inform the work of front line professionals. We see children and their families to assist social workers and child protection conferences, as well as the Family Courts. Our work includes, but is not limited to the following:
   — assessments of risk;
   — assessments of harm caused to children;
   — determinations of non-accidental injuries; and
   — evaluating possibilities for therapeutic work with parents and children, including decisions regarding removal of children or return of children to their families.

3. We provide diagnoses of parents, along with evaluation of how any mental difficulties they might have affect their ability to care for their children. We detect, assess and diagnose mental illness, personality disorder, mood problems, drug and alcohol abuse and learning difficulties.

4. We also assess the mental health of children. This is important, since although child mental illness is recognised increasingly, it is also frequently missed, along with the needed and timely treatment and intervention. Diagnoses we provide for children include learning difficulties, ADHD, post-traumatic stress disorder, depression and autistic spectrum disorders.

5. Providing understanding of the inter-related social and mental health problems in a family assists child protection teams in working with family members to address their difficulties.

6. In the course of our assessments, we often discover abuse that had not been detected previously.

7. There is now a crisis in expert witness availability, particularly in London. The Government has reduced experts’ fee rates57 to the point that many can no longer afford to offer this service. The Government has cut the level of funding for those working in London to just two thirds of those working outside of London. The rationale for this difference, which particularly penalises the child protection system in London, is explained by the Government in terms of competition, without regard to the needs of children in London.58

8. Senior clinicians are already withdrawing from this work. Their experience, built up over many years, will be lost to the child protection system.

9. Also, if the Government’s Legal Aid bill is passed, many families involved in private law disputes will not have the benefit of legal representation or the help of expert witnesses. Yet, we find that the children in these families, engaged in private law proceedings, can be significantly emotionally abused.

10. We believe that the Government is failing to prioritise the needs of children, as mandated by The Children Act 1989.

October 2011

57 The Community Legal Service (Funding) (Amendment No. 2) Order 2011.
58 Proposals for the Reform of Legal Aid in England and Wales, Consultation Paper CP12/10, November 2010, said in paragraph 8.10, “This reflects the greater supply of experts in London, which allows more competitive rates to be paid.” However, other consultations during the same period referred to a shortage of expert witnesses, country-wide. The Ministry of Justice did not provide any data to prove their assertion.
Written evidence submitted by the Association of Child Psychotherapists

1. Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

1.1 Effective identification

Effective identification in the present system depends on the involvement of all parties coming into contact with children across home and community eg family members, nurseries, schools, health staff, those providing out of school activities etc. However, the statutory responsibility rests with social services departments.

Social services departments are overstretched and social workers sometimes become overburdened and defensive. It is then less likely that they will be able to respond to concerns and to communicate effectively with members of the public and with colleagues in other agencies.

1.2 Early Help

What is “early help?” and to whom should it be provided, by whom and at what point in time? Research and evidence across sectors points out the emotional and economic benefits of families receiving “help” at an early stage of their child’s life and development. This might take the form of support from a health visitor in the family home or local Sure Start or other community based support. At the extreme end of intervention, inpatient care in a mother and baby unit could be defined as appropriate “early help.”

1.3 Summary

The current system is not always effective in the tasks of (a) identifying when children are at risk of abuse and exploitation and (b) providing early help to those who are.

The reasons for this are clearly complex, as outlined in the Munro Report earlier this year, and solutions are unlikely to be quickly implemented. However it is imperative that local multi agency solutions are sought to address the obstacles to effectiveness at a regional level. We would very much echo Professor Munro’s emphasis on the culture of the system needing to evolve from one of compliance towards one of learning.

2. Factors affecting the quality of decision-making in referral and assessment, and variations across the country

2.1 Factors affecting the quality of decision-making in referral are complex and highly dependent upon who is making the referral and why. In most, if not all instances, quality is improved through the process of dialogue and reflection. It is hugely anxiety-provoking to feel worried about a child’s welfare and it is vital that those working with children and families are able to share their worries or uncertainties. In our view as child psychotherapists, one key to effective assessment is observation of the child or children (and their parent/s) in various contexts.

2.2 Deterrents in recognising and responding to concerns about children are of paramount importance when considering the quality of referral and assessment. These include:

(i) **Deterrents in the child**: Children and young people often feel powerful loyalties towards their parents or carers, even when they are abusive or neglectful. Even experienced professionals can confuse a particularly strong or intense attachment between child and their parent(s) or carer(s) with what is actually in the child’s best interests.

(ii) **Deterrents in the parent/carer**: In severe cases of child maltreatment, perpetrators are likely to be highly motivated to avoid detection, and may be skilled in manipulating children and adults and creating confusion amongst family and professional networks.

(iii) **Deterrents in those working in child protection**: Reluctance to raise the question of abuse when the professional commitment is to supporting families can lead to unintended neglect of the signs of maltreatment. There may also be conscious or unconscious fear of hostility from parents and/or children.

2.3 The impact of “professional fatigue” is also an important one. Many “hard to help” young people have long histories of involvement with children’s social care and other specialist agencies. Over time, professional fatigue can set in, leading agencies to run out of helping strategies and become reluctant to continue to follow up suspicions of maltreatment. As a result, the needs of this older age group are often “neglected” by the authorities, repeating patterns of earlier neglect in the family.

2.4 Other factors relating to quality of referral might include a lack of knowledge about child development. Belief remains widespread, for example, that babies are not affected by emotional neglect or abuse or, for example, by witnessing domestic violence, despite robust and extensive evidence from developmental, neurological and attachment research that, on the contrary, children are most vulnerable to the effects of emotional neglect and abuse in their first year of life. Nearly 50% of serious injuries or fatalities as a result of
maltreatment are to infants under one year of age and pre-school children are at greater risk of undetected maltreatment because they are assumed to be doing well enough if they eat, sleep and achieve basic milestones.

2.5 Quality of assessment is variable within regions and across regions, with many local authorities’ under-resourced and using agency staff. Assessment in child protection is difficult, skilled and precise work. It requires fine judgement, an ability to assess and judge risk and a high level of both competence and confidence. It is also not a one-person enterprise. All assessment should be a shared endeavour and involve multiple minds. In practice there can be a tick box culture within some departments which encourages staff to rely on form filling rather than thinking and talking about the cases. Many social workers are actively encouraged to remain emotionally detached from the work they do, as any subjective feeling is thought to inhibit “objective” decision-making. This clearly inhibits each worker’s capacity to use their own judgment about what they have directly experienced.

2.6 The quality of assessment can be enhanced through effective team and interagency working and through effective management and supervision. It is a relationship-based activity rooted in relationship-based ways of working. It is also enhanced through reflection and discussion. It can be very helpful for those undertaking assessment to have good working knowledge of issues of power and coercion.

3. Appropriate thresholds for intervention, including arguments for and against removing children from their families

3.1 The phrase “appropriate thresholds for intervention” is inevitably ambiguous. Section 47 of the Children Act 1989 and its phrase “at risk of significant harm” has served to guide social work and multi agency practice in this sphere. Practitioners, often in liaison with legal colleagues, are then left to interpret what this means in its application to individual children and their families. Unfortunately, in our experience, this can lead to an “evidence gathering” approach rather than a more holistic assessment approach rooted in multi agency reflection.

3.2 Social work intervention can feel “damned if it does and damned if it doesn’t” in terms of the removal of children from their birth families. In our experience the early stages of interventions in the lives of children at risk and their families too often lack sophisticated, multi-agency assessment.

3.3 Key to shifting from a compliance culture in safeguarding towards a learning one might be an attempt to reframe the notion of arguments for and against removal into something closer to “frameworks for assessment and treatment/intervention”, which can offer the prospect of change, growth or development.

4. Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

4.1 Breakdowns in effective dialogue and collaboration across agencies are recurrent features of serious case reviews. It can be difficult to assess the impact of policies on practice.

4.2 “Working together” across agencies is notoriously hard work. Effective working can be challenging, painful and exposing. A high level of consultation and supervision is required to enable individual members of networks to disentangle their personal predispositions and identifications from a more objective position.

4.3 It is helpful for reflective and effective collaboration to be modelled at the very top across government departments and within non social work agencies.

5. A note on the Association of Child Psychotherapists

The ACP is the main professional body for psychoanalytic child and adolescent psychotherapists in the UK. Our 850 members work with infants, children and young people and their parents, families and wider networks. They also play an important role supporting other professionals who work with children and young people, including teachers, social workers, youth workers and other mental health professionals, through training, supervision and consultation. Most child and adolescent psychotherapists work within the NHS as part of CAMHS teams. They also offer their skills in a range of specialist areas, for example as expert witnesses in the family courts and as members of looked after children teams and adoption panels.

November 2011
Written evidence submitted by the British Association of Social Workers (BASW)

1. BASW is the UK professional association for social work, led by and accountable to a growing population of approximately 14,000 social worker members. Our members work in frontline, management, research and academic positions in all social work settings across the UK. BASW members share a collective commitment to those values and principles that will secure the best possible outcomes for children and young people, adults, families and communities.

INTRODUCTION

2. The focus on child protection services in England became particularly acute following the death of Baby Peter in 2007 and the subsequent heightened media and political interest that followed in 2008. The social work profession in particular was under the spotlight and the previous Government decided that it was in order to set up a Social Work Task Force to address the standing of the profession across the piece. BASW made a significant contribution to the work of the SWTF; firstly, BASW’s development manager Bridget Robb was appointed to the taskforce. Secondly, BASW spent a lot of its time in consultation with its members on all aspects of social work in order to produce substantial and informed responses to the work of the SWTF and its successor the SWRB of which BASW is a partner organisation and sits on its various groups.

3. In June 2010, BASW was delighted that one of the first acts of the coalition Government was to commission an independent review of child protection led by Professor Eileen Munro. Professor Munro is well respected by the sector and it was refreshing to have a review of child protection led by someone of such high calibre and with the relevant expertise. Once again, BASW’s members working in the field of child protection were royally rewarded with the opportunity to respond to the calls for evidence. BASW’s Chief Executive Hilton Dawson together with our UK Chair Fran Fuller and Janet Foulds (member with substantial experience in child protection, specialising in working with children who have been sexually abused) met with Professor Munro to present our evidence and discuss the way ahead.

4. However, three years on from the intense scrutiny following the death of Baby Peter many frontline social workers and their managers are feeling incredibly frustrated as their task has not necessarily improved but conversely been made even harder. With the number of activities that have been carried out as described, social workers expectations were understandably raised hoping for much needed change. It is now well documented that the task of protecting children had become skewed by an overly bureaucratic process including inspection often heavily weighted towards measuring whatever is measurable rather than interrogating more qualitative data. Social workers are so constrained that their ability to exercise professional judgement has become increasingly limited in a risk averse culture characterised by blame were the stakes are unacceptably high.

5. The previously described situation is further exacerbated by the austerity measures that are being implemented across public services in light of the current economic situation. Whilst there have been public reassurances that frontline social work posts will not be cut, BASW members are reporting that in some places, this is happening; for example, if a social worker leaves they are not being replaced as their post is frozen. We are also being told that cuts are being made to other parts of the service such as support workers and administrative workers which has a deleterious effect on social workers as more work is simply loaded onto them.

6. We are also seeing good, experienced people exiting the profession as their workload and caseloads increase exponentially and they worry that this will lead to unethical practice. Conversely, some newly qualified social workers who are entering the profession are also experiencing burnout and leaving prematurely in some cases the social work profession altogether which is a waste of talent. This is not a good situation and whilst we accept that the Munro recommendations will take some time to embed, services are severely overstretched which could lead to even more tragedies if we are not careful.

7. Community Care carried the headline on 30 September 2011 that a quarter of councils were not protecting children adequately. BASW suspects that the reason for this in the majority of cases is likely to be the lack of capacity and resources available to meet the needs of children at risk. (see Appendix Major BASW survey reveals child protection risks of current system) This is demoralising for both individuals, services, the public and children. Moreover, the reviews led by Professor Munro, Graeme Allan, Clare Tickell and Frank Field all extol the virtues of early intervention and preventative work. This seems a million miles away from the reality on the ground but clearly does need to feature heavily in services to children and families to create a more balanced, less crisis driven and cost effective service that will actually save more money in the long term.

8. The Hackney model in children’s social care is testimony to this; basically, children’s social workers are being deployed very differently working as consultants in multi-disciplinary teams. Evaluation of the effectiveness of this model demonstrates that the number of children being taken into the care system has reduced as a result of effective intervention with children and families living in the community.

EXECUTIVE SUMMARY

9. Child protection workers whether they are social workers, police officers, health workers or others are often unsung heroes who go about their work quietly and conscientiously making a huge difference to the lives of our most vulnerable children in England. In some cases, their intervention saves lives. The public needs to
have a far more balanced picture of the effectiveness of the child protection system and employers, local government, the media and politicians can all play a critical role in making the good work that takes place more prominent and better understood. Professionals charged with protecting children need society’s backing and those in positions of power and influence to champion their cause.

10. Too often, the consistency and quality of services available to children in need of protection is variable across the country. Some of this is due to the post code lottery and the agenda for constant change making it difficult to consolidate positive initiatives. There is also a demand by those in power to work smarter but this can only be done by having a sufficiently skilled, valued and supported workforce. Plugging the recruitment and retention gap in social work services is critical and part of the solution lies in developing an effective career progression for children and families social workers.

11. The impact of cuts to public services is already having a devastating effect on child protection services. Workloads are rising whilst capacity is decreasing both within local authorities and its partner agencies in the third sector. Essentially, this will end up costing the tax payer more and does not square with the emphasis placed on early help and preventative work in recent Government sponsored reviews.

12. Finally, more specialist areas of work such as forced marriage, child trafficking, child sexual exploitation and female genital mutilation are likely to suffer and remain on the margins rather than be mainstreamed into child protection services. Inevitably, the most vulnerable children will remain largely invisible and fall through the gaps. Even more recognised areas such as domestic violence are now being relegated in terms of priority being given to cases in terms of risk assessment, changes in legislation and policy and allocation of resources. This does not bode well for the thousands of children and families who live in these situations. If we are not careful, many of the advances we have made in protecting children could be lost at great human cost.

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

13. There have been various reports about the effectiveness of agencies and professionals abilities to identify the potential and actual risk of abuse to children. In 2009, Ofsted reported that agencies working with children more generically such as education were not adequately identifying basic indicators of abuse which was worrying. On the other hand, an article in teaching experts in 2010 highlighted the benefits extracted from research on the Common Assessment Framework in helping agencies work together to provide positive outcomes for families. In truth, effectiveness is likely to be patchy, subject to the quality of leadership in an organisation, the training and support that is available (see Appendix Survey finds social work employers risking safe practice), the experience and qualifications of the workforce, adequate resources, established relationships and protocols across agencies and consistency and commitment to strategies (at times, effectiveness can be greatly undermined by a change in policy direction, jeopardising what is already in place preventing any consolidation).

14. Good practice needs to be highlighted and shared universally so that others can learn from it and apply it. Often, there are pockets of good practice which may even have been evaluated but not enough is being done to build a comprehensive evidence base to tell us what works. (We note that the Munro Review specifically asked for examples of good practice and a number are included in the various reports) This can also make particular projects very vulnerable to funding as they may be regarded as a luxury and see their funding withdrawn. There is an issue here for Councils and LSCBs in respect of commissioning arrangements and making decisions that are in the best interest of protecting children’s welfare. We need a longer term commitment to resourcing effective services and some ring fencing of money in the pot.

15. Domestic violence is a case in point, as Women’s Aid report significant cuts in provision which have seen a reduction in both accommodation for those fleeing domestic violence and support services in the community. This is further compounded by the Legal Aid, Sentencing and Punishment of Offenders Bill making its way through Parliament which in its current form will make it much harder for victims of domestic violence to be adequately protected by the courts. Community Care magazine also reported recently that some social work departments were re-categorising domestic violence cases from children at risk cases to children in need cases because of resources. This is all extremely worrying and feels as if we are turning the clock back on some of the excellent progress that has been made in this area over the last 20 years. Sadly, time and time again Serious Case Reviews tell us that where a child has died domestic violence has also been a factor. We need society's backing, government, the media and politicians can all play a critical role in making the good work that takes place more prominent and better understood. Professionals charged with protecting children need society’s backing and those in positions of power and influence to champion their cause.

16. BASW applauds some of the ground breaking work that has been done in the area of trafficking, forced marriage, female genital mutilation and online exploitation in recent years. It is inspiring to hear about some of the initiatives that have been taken to address these very challenging issues which involve working at a local level and also outside of the jurisdiction of the UK. Nevertheless, these are still issues that are given very little or no priority by some agencies in some localities. This is clearly not acceptable given that children and young people at risk of trafficking, forced marriage and female genital mutilation are likely to have even less of a voice than other children. There needs to be a clear auditing process in place that would help us to interrogate the effectiveness of agencies across the country to deal with these issues. We would suggest that LSCBs have a vital role to play in collating information pertaining to key areas which should include child
sexual exploitation, children who run away, asylum seeking children as well as the categories already identified. Whilst as stated previously, some pioneering work is being undertaken in these areas there is still a real danger that more vulnerable and isolated groups of children are being missed and will disappear through the cracks if we do not get a better handle on this.

Factors affecting the quality of decision-making in referral and assessment, and variations across the country

17. Firstly, it is important to acknowledge that there is some excellent practice going on in child protection in England delivered by individuals on behalf of their agencies which is rarely commented upon. The tendency is always to focus on the negative putting a poor complexion on services in general. We think it is important to cultivate a “learning culture” as espoused by Professor Munro in her inquiry. The media and politicians therefore, need to be proactive in getting good news stories out to the world at large about the work of child protection workers so that there is a better awareness of these issues in society which will ultimately improve the status of the work, the morale of professionals and ensure that children in need of protection receive the right level of support from services.

18. As stated in the previous paragraph, resources and quality of the workforce are significant factors that impact the quality of decision-making. The SWTF quickly established that there is a lack of experienced social workers and first line managers in the workforce putting more pressure on those with very little experience to undertake tasks that they are not equipped to handle. Other public services such as the police and health have also experienced cut backs to their personnel and given the more generic nature of these services, child protection may be given less priority than other areas of work. Unfortunately, reductions in public services is not matched by need; since 2008, referrals to children’s services departments have increased which has had a ‘knock on’ effect on other parts of the system given that care applications to court have also increased and consequently the population of children in care has grown. This has led to many social workers having too many cases making it extremely difficult for them to devote the time and attention they would like to an individual case. The assessment process has also not been helped by an over prescriptive system (as documented in the Munro Review). Many of our members feel that the assessment task in some cases represents little more than a snapshot of a situation and is not flexible enough to provide a more in depth view of a child’s situation. Strategy meetings between police and social workers are more often than not over the phone which may be appropriate in some cases but not all; thorough and effective assessment is vital to the successful protection of children and should not be short circuited. However, the latter simply represents the inordinate pressures services are under with finite resources and their strategies for survival.

19. It is our contention that child protection must be seen as an absolute priority in this country and requires proper investment; the analogy of more from less simply cannot and must not be applied to this area. Children must receive services from a skilled and confident workforce that is well supported in terms of training and good supervision (see Appendix BASW/CoSW calls for consistent supervision support). Sadly, we know that another area that is vulnerable in terms of the cuts agenda are training departments. Reducing training opportunities for professionals in child protection work represents a huge own goal and runs counter to any attempt by Government to improve policy, issue directives and implement new programmes. This is a futile exercise if the workforce is not supported and equipped to carry out the task.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

20. BASW would agree with most commentators in this area that our childcare legislation (in particular, the Children Act 1989) provides a sound framework to undertake the task of protecting children. Moreover, we believe that it holds in balance principles about the sanctity of the family and the importance of maintaining a child within their family and intervening where necessary in removing children from their families if the risk is deemed unacceptable.

21. However, the interpretation of legislation of course can be a more complex issue. Whilst we have consistently argued throughout this submission for the need for sufficient expertise in the workforce to arrive at decisions about the welfare of children there are many other contributory factors that can impair the decision making process given that they are not necessarily compatible with the best interests of children. Many of our members report that other parts of the infrastructure which are removed from the coalface and more concerned with budgetary matters can conversely effect decision making processes in respect of approval for resources. There is strong evidence that finite resources mean that some children are given greater priority by the system whilst others are left more vulnerable. This is not acceptable—the welfare of children must come first. The process should not be skewed by monetary considerations. Social workers must also have access to good legal advice from their departments but ultimately decisions to remove children from their families should be taken by welfare professionals and not be usurped by others.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

22. We would certainly agree with the recommendation in the Munro Review to significantly revise the Working Together guidance to make it workable for those on the frontline. Practice guidance would be far more preferable to the voluminous tome that we presently have. It is difficult to say whether or not the policies
and practices of non-social work agencies per se assist professionals to work together in the best interests of the child as that would be making a huge sweeping statement. We know that in some cases they do and some they do not. The real issue is how we can develop more effective and consistent services to children and young people across the country. Clearly, they need to be child centred services informed by the experiences of children and young people. As stated previously, there are pockets of good practice but not enough dissemination or resources to reproduce it more widely.

APPENDIX

MAJOR BASW SURVEY REVEALS CHILD PROTECTION RISKS OF CURRENT SYSTEM

1 October 2010

Seven in 10 social workers say they have experienced situations where they have been unable to protect a child because of the constraints of the job they do, according to the findings of a major BASW survey of the profession.

The survey of 1,373 social workers, carried out in conjunction with ITV’s Daybreak breakfast programme, found that 95% of respondents believe they spend too much time on paperwork and not enough with children and families. The result reaffirms the basis of the government’s decision to ask Eileen Munro to investigate ways of reducing bureaucracy within children’s social work and prompted BASW to emphasise the need to spare social work from cuts.

The online BASW survey, carried out during September, also highlighted serious concerns among professionals about the impact of possible spending cuts, with 94% of the view that this will impact negatively on child protection services.

The pressures of child protection work are evident in the 68% of respondents who said the work has caused them “emotional or mental instability”, with 45% of these admitting to having taken time off work as a result.

The survey’s publication coincides with the emergence of Professor Munro’s first report, in which the academic makes a range of initial observations about the excessive guidance and bureaucracy professionals have to endure. However, social workers are not yet confident her work will secure positive results, with just 46% suggesting it would improve child protection.

Responding to the findings BASW said it was not surprising that social workers are not yet ready to believe solutions are at hand, pointing to previous failed initiatives and the threat of cuts dominating the public sector landscape.

In a statement the Association added:

“These survey findings offer a stark illustration of the realities of professional life for social workers throughout the UK. High caseloads, low morale, poor recruitment and retention levels, a damaging and often unfair media depiction and weak or nonexistent training and supervision.

“For the sake of the vulnerable people who rely on often extraordinary social work services, including children at risk of serious harm, there must be a massive, sustained political effort to renew the profession. This needs to start with a commitment from the Treasury and from local government not to cut funding for social work services.

“Social work missed out when health and education received significant investment from the previous government, with clear and damaging consequences, and so cannot now be expected to cope with funding cuts. Instead it needs a clear and continued commitment from policymakers to work towards a stronger profession.”

SURVEY FINDS SOCIAL WORK EMPLOYERS RISKING SAFE PRACTICE

12 April 2011

BASW—The College of Social Work is calling on employers to recognise that many social workers are practicing in unsafe conditions without receiving even the most basic levels of support. Launching the first stage of a Supervision Policy, outlining the support social workers should expect from their employer, BASW/CoSW highlighted research showing that professionals aren’t getting the support they need.

Ninety% of social workers say they need professional supervision at work at least once a month but the reality is that only 40% receive such support once every two months or less, with 11% never or rarely receiving it. A huge 71% of social workers do not feel their supervision adequately covers emotional issues that arise in practice.

The failings come against a backdrop of unmanageable and complex caseloads, a lack of resources and huge public spending cuts.

Fran McDonnell, Policy Officer at BASW—The College of Social Work said: “Supervision is an absolutely vital element to successful practice, to social workers confidence, morale and in some cases mental health.
This survey shows that many social workers are not getting even the most basic of requirements from employers which jeopardises the quality of support they can provide to families most in need."

BASW—The College of Social Work Policy Committee has just launched the UK Supervision Policy for member consultation and, following feedback, will urge social work employers to adopt the policy and prioritise supervision.

“Good supervision isn’t a negotiable benefit,” Fran added. “It is intrinsic to the role and it keeps social workers focussed and able to do a good job. It gives them an opportunity to reflect on their practice and make well informed decisions based on the Code of Ethics, practice standards and within country legislation. Professional support and supervision should be provided by appropriately experienced social workers. We are looking forward to taking this policy to employers to ensure that standards in the profession are driven up.”

The online survey also found that over half do not feel their supervision covers accountability issues or personal development and training issues. The BASW—College of Social Work Supervision Policy defines quality supervision for employers and offers practice guidance for social workers on supervision.

BASW/CoSW Calls for Consistent Supervision Support

12 April 2011

BASW—The College of Social Work (BASW/CoSW) is calling on employers to ensure social workers receive regular supervision in order to make sound judgments and maintain high professional standards. Publishing a 12-point draft policy on supervision the Association said it is urging employers to guarantee weekly supervision for newly qualified social workers and offer more experienced practitioners similar support at least once a month.

BASW/CoSW is asking members to read the guidance and share their opinions on it with the Association, as well as present it to their employers as a programme for potential implementation.

The guidance has been drawn up amid growing concern that social workers are being forced to practise without adequate supervision. There is also disappointment that the Social Work Reform Board, which is implementing the recommendations of the Social Work Taskforce, decided against compelling employers to ensure minimum levels of supervision for social workers, a decision condemned by BASW/CoSW.

BASW/CoSW says supervision improves confidence, competence and morale among social workers but is currently being delivered inconsistently across the country. A snapshot survey, carried out by the Association in late 2010, found that almost half of respondents (45%) were dissatisfied with the frequency of their supervision and more than a quarter (27%) rated it as poor. More than 70% said it did not adequately cover the emotional issues that arise from social work. Although more than half of social workers receive supervision once a month, more than 10% said they rarely, if ever, got it.

The BASW/CoSW guidance, on which it is urging members to share their views, restates the importance of supervision in social work, stating:"

“The lack of supervision or the over emphasis in recent years on the managerial aspects of supervision, has led to the reduction in the reflective aspects of supervision, loss of professional autonomy in decision making and a poorer service for service users.”

It says that any organisation that employs social workers should have a strategic lead social worker with responsibility for developing a strong supervision culture through a supervision policy, agreements or contracts and effective training of supervisors.

November 2011

Written evidence submitted by the General Medical Council (GMC)

INTRODUCTION

1. The GMC is the independent regulator of doctors in the UK. The GMC protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine.

2. We do this in four ways:

   (a) By controlling entry to and maintaining the list of registered and licensed doctors.
   (b) By setting standards for and co-ordinating all stages of medical education and training.
   (c) By determining the principles and values that underpin Good Medical Practice.
   (d) By dealing firmly and fairly with doctors whose fitness to practise is in doubt.

3. We welcome the opportunity to respond to this inquiry into the Child Protection system in England. We note that the inquiry addresses a number of issues that fall outside the GMC’s remit. Our response relates principally to Q4, although some points may also be relevant to your other questions.
4. Doctors play a crucial role in child protection. We are currently developing new and more detailed advice for doctors to help them understand and act on their responsibilities. In developing the guidance we have heard from a wide range of organisations and individuals and have amassed a substantial body of evidence relating to experiences of doctors, other professionals, parents and children. Overall, doctors are seen to play an important role and to do so with dedication, skill and sensitivity. Some difficulties in inter-agency and multi-disciplinary working have been raised, and while these are necessarily highlighted in our response, they do not represent a complete picture of doctors’ practice.

THE ROLE OF THE GMC IN DETERMINING THE PRINCIPLES AND VALUES THAT UNDERPIN GOOD MEDICAL PRACTICE

5. The GMC issues guidance to doctors on standards and professional conduct, performance and medical ethics. Our core guidance to doctors Good Medical Practice (2006) describes what is expected of all doctors registered with the GMC. Good Medical Practice is supplemented by a range of more detailed guidance documents covering specific issues, for example consent and confidentiality, and on working with patient groups, such as children. We already give advice on the important role doctors can play in protecting children from abuse or neglect in our guidance 0–18 years: guidance for all doctors. However, in spring 2010 it was agreed that the GMC could helpfully provide more detailed advice on the issue.

6. A Working Group to take this work forward was set up in July 2010. It is chaired Lord Justice Thorpe with members representing medical and social work professions, and parent and children organisations. The Group was asked to produce new guidance setting out good practice in dealing with the difficult decisions that arise when a child is, or may be, subject to abuse or neglect.

7. The draft guidance, Protecting children and young people: the responsibilities of all doctors, gives advice to doctors on confidentiality, consent, communicating with families, training, inter-agency working and giving evidence in court. The draft guidance has been developed in the light of written and oral evidence from a wide range of individuals and professional bodies, including social workers, nurses, lawyers and doctors, as well as parents and children, about the roles and responsibilities of all doctors working to protect children and young people.

8. The formal public consultation was launched on 27 June 2011 and run until 14 October 2011. We expect to publish the finalised guidance in spring 2012. http://www.gmc-uk.org/guidance/news_consultation/8411.asp

THE ROLE OF ALL DOCTORS

9. It is important for all doctors to cooperate and communicate effectively with colleagues, and with other professionals and agencies in the interest of children and young people. This is reflected in our core ethical guidance, Good Medical Practice, which sets out the high-level principles of good practice and the standards expected of registered doctors, and in the supporting booklet: 0–18 years: guidance for all doctors. This currently advises doctors to:

“… participate fully in child protection procedures, attend meetings whenever practical and co-operate with requests for information about child abuse and neglect.”

10. We also advise that doctors “should make sure that there are clear and well-understood policies and procedures for sharing information with agencies you work with closely or often. You should have an understanding of the roles, policies and practices of other agencies and professionals. This includes understanding the circumstances in which they consider disclosure to be justified.”

IMPORTANCE OF MULTI-DISCIPLINARY WORKING

11. During the development of the draft guidance on child protection, we invited those with an interest in child protection to respond to our call for written evidence. This was the first major step in the evidence gathering process. We encouraged respondents to share their views and to provide examples from their own experience about doctors’ roles and responsibilities in child protection work.

12. When asked for views or experiences about how well doctors work with other professionals and agencies; respondents generally indicated that relationships had improved but there were still some areas of concern and room for improvement. Whilst overall reports were of positive experiences, there was concern that the willingness and ability to work effectively with others varied depending on the role of the doctor concerned.

13. The issues raised with us fell into four main areas:

(a) engagement with child protection including attending case conferences and providing reports and information;

(b) sharing information;

(c) identifying children at risk (particularly where doctors are treating adult patients only); and
(d) training.

14. Whilst each respondent had their own perspective, there was a common shared sense of the challenges in this area. These included concerns about some doctors, often those who worked only with adult patients, not understanding this area of work or regarding it as falling outside their responsibility.

15. Other respondents commented on an apparent unwillingness to be involved in the child protection process, seeing this as a result of the competing demands of their roles, rather than a lack of concern about children. GPs in particular were often faced with difficult decisions about what to prioritise, particularly when case conferences were called at short notice, cutting across GP surgery or clinic hours. Many doctors felt that they would have little to contribute at a child protection meeting, and their time would be better spent with other patients to whom they had a duty of care. It may be that more flexible ways for getting doctors’ contribution to the care of children at risk or in need of protection, can be found.

16. Many respondents felt that multi-disciplinary training would be helpful, so that all the professions involved understood the roles, expertise, and problems faced by colleagues in other parts of the service.

17. In light of this, the GMC draft guidance, Protecting children and young people: the responsibilities of all doctors, has been developed by taking on some of the broad issues emerging from the written and oral evidence. In the draft guidance we state the importance of working in multi-disciplinary settings and advises doctors to:

- understand the roles of other professionals and agencies with child protection responsibilities;
- take part in child protection procedures, which may include providing reports and attending or contributing to meetings;
- know who your named or designated doctor for child protection or lead clinician is and how to contact them; and
- to participate in training for multi-disciplinary teams or by sharing best practice and skills.\(^{61}\)

**CONSENT TO TREATMENT AND EXAMINATION**

18. Doctors who work to protect children must keep the interests and needs of the child at the centre of what they do. This means listening to children and giving them information in a way they can understand; and examining or treating children with their consent, parental consent or other legal authority. It may also involve doctors sharing information about the child and family with other agencies or when acting as a witness giving evidence to the court in order to provide services for the family or to protect a child from abuse or neglect. In these circumstances, the child and their family may have conflicting interests.

**INFORMATION SHARING AND CONFIDENTIALITY—BALANCING THE DUTY TO SHARE**

19. The GMC currently advises doctors that:

> “Confidentiality is important and information sharing should be proportionate to the risk of harm. You may share some limited information, with consent if possible, to decide if there is a risk that would justify further disclosures. A risk might only become apparent when a number of people with niggling concerns share them. If in any doubt about whether to share information, you should seek advice from an experienced colleague, a named or designated doctor for child protection, or a Caldicott Guardian. You can also seek advice from a professional body, defence organisation or the GMC. You will be able to justify raising a concern, even if it turns out to be groundless, if you have done so honestly, promptly, on the basis of reasonable belief, and through the appropriate channels.”\(^{62}\)

20. In the draft guidance we will be further explaining doctors’ responsibilities both to maintain a relationship of trust with all patients—so that patients, including parents, feel able to share information freely with them—and to share information with professional colleagues to protect and promote the interests of children. This is a difficult path to tread, but we hope that the more detailed guidance will help doctors to find the right balance between their duty to protect children and to respect the rights of the family. Our new draft guidance states that when responding to requests to information, doctors should take all requests for information for child protection seriously and respond promptly, taking into account that any delay or refusal could increase the risk of harm, or undermine efforts to protect a child or young person.\(^{63}\)

21. A clear theme arising from the written evidence was the difficulties doctors can face in prioritising children’s welfare (and even concerns about child abuse or neglect) because of a perceived or real conflict with parental interests or the pressure it brings to their relationship with parents, who are also their patients. GPs were most frequently cited as facing this problem. A doctor wrote that GPs can experience an emotional barrier to referring child protection concerns, feeling a sense of betrayal to the parents, with the dilemma intensifying if the diagnosis or opinion is unclear or later found to be unjustified. Problems arise particularly when the GP is aware of risk factors in the family eg domestic violence, alcohol misuse/dependency and substance abuse.

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\(^{62}\) 0–18 years: guidance for all doctors (paragraph 60)—GMC (2007).

\(^{63}\) Protecting children and young people: the responsibilities of all doctors (paragraph 38)—Draft guidance—GMC (2011).
made worse because GPs are not accustomed to sharing information with non-medical colleagues. One PCT wrote that doctors are sometimes more concerned about maintaining relationships with a family rather than protecting a child.

22. Our guidance is intended to help doctors identify those cases where sharing information about children and their families will help to support the child and family; or where action should be taken to protect children from risk of harm.

**Sharing Information**

23. One of the key challenges identified from the oral evidence session was doctors knowing when and with whom confidential information should be shared, especially in situations where there is uncertainty.

24. Concern was also expressed that doctors working with adults may not regularly consider the needs of their patients’ children. This is an area which we will focus on during the implementation of our guidance. We will be using a range of fact sheets, case studies and other materials to help in raising all doctors’ awareness of the need to “think children”.

**Barriers to Involvement**

25. Several respondents commented on the challenges faced by working with other professionals who may have different thresholds for intervention. It was also noted that these thresholds may be related to the availability of resources—some GPs reported that they had referred families to children’s social services departments because they perceived a child to be at risk, but were told that the risk did not meet the threshold for intervention. This is clearly a challenging issue. As has been noted, child protection is multi-disciplinary and it must be a cause of frustration for those who perceive a risk that does not meet the threshold of other agencies.

26. In the draft guidance, we advise doctors who suspect a child is at risk of abuse or neglect, to “escalate concerns if you believe that an initial referral to another agency has not been responded to appropriately and a child or young person is still at risk of abuse or neglect”. 64

27. When asked about factors that help or hinder clarity about roles and responsibilities to protect children and young people, respondents identified issues that can be grouped into three core themes: professional remits; training and guidance; and local working arrangements.

28. Respondents were generally in agreement that it would be helpful for all professionals and agencies to be aware of the scope for involvement of doctors. Currently, interpretations of what involvement doctors in different specialities should have causes uncertainty about overall responsibility to protect children and young people. The question of GPs’ involvement and engagement was raised and compared with the role played by paediatricians. One healthcare professional said that in their experience safeguarding is not the GPs speciality and are not comfortable taking a lead in this area of work, but in general they were aware of their role and of the GMC’s expectations.

**Training**

29. Inter-professional and inter-agency training and guidance about child protection work was widely recognised as a means of helping to clarify roles and responsibilities. Inter-agency training was seen as a way to widen understanding of the various roles and responsibilities in child protection work highlighting individuals with experience of child protection work, and helping them to better understand the child protection work carried out in their local context. A primary care child safeguarding forum found it worked well with using practical examples when conducting multi-agency training with GPs; and a NHS trust found that regular training helped to identify professionals with child protection experience and ensure they seek advice when needed.

30. The GMC is committed to ensuring our advice and supporting materials to doctors will assist professionals to work together in the interest of children and young people. The draft guidance will be published in spring 2012 and we will be happy to share this with the committee.

*November 2011*

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64 Protecting children and young people: the responsibilities of all doctors (paragraph 35)—Draft guidance—GMC (2011).
Written evidence submitted by Parents Against Injustice (PAIN)

1. Parents Against Injustice (PAIN) is a voluntary organisation which has for the past 26 years advised and supported parents and carers who claim that they have been falsely accused of abusing the children in their care. We receive around 500–600 enquiries a year through our parent helpline, email and social networking but expect our caseload this year to exceed 1,000. We therefore feel that we are uniquely placed as a leading advocate for parents to say where the system is ineffective and unfair—and fails not only the parents but, as a consequence, their children.

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation

2. A large number of our cases involve unsubstantiated allegations of child abuse and the system must address the full extent of this problem and bring in changes so that identification of actual cases of abuse is made easier. It is our greatest concern that children are being removed to innocent families severely traumatised following their removal. We have cases where removal has only lasted a few days yet the emotional damage in the children is evident years afterwards. Of equal concern is the effect on the health of parents, both physical and mental, and which again has serious consequences for the development of the children involved. Effective identification of actual abuse is therefore crucial but presently the system fails on many levels.

3. The constant theme running across many of our cases is the lack of support offered to parents and carers especially at the stage of early intervention. With the absence of this support unnecessary intervention is triggered into family lives and many of our case histories resonate with the cries of parents saying “never again” or “if only I hadn’t sought help”. Irreparable damage has been done by then but which could easily have been avoided with focused support as opposed to a mistaken belief that abuse had been identified.

4. An increasing barrier to effective identification however is the growing fear of parents that social services will remove their children at the drop of a hat. This perception has grown rapidly in recent years primarily as a result of social networking on the internet and the consequence is that some parents are reluctant to seek help and support which inevitably means that children could be placed at risk of abuse.

5. Sue Amphlett, the founder of PAIN, wrote as far back as 1998 that the most effective way to disempower anyone is to keep them in the dark so not only do you render them unable to understand what is happening but you also prevent them from contributing to what is happening and from influencing the outcome of what is happening. Regrettably, little has changed to improve the system since those words were written.

6. If child abuse is identified and substantiated we see a diminishing opportunity for families to work in partnership with the same people who may be trying to remove their children. We therefore argue that to support families to stay together the social work function should be split into two: family support workers and child protection workers—as the social worker’s mission to empower the service user is otherwise compromised.

Factors affecting the quality of decision making in referral and assessment and variations across the country

7. The quality of decision making is not only influenced by the quality of training and professional skills and expertise of the social workers involved but in learning from past mistakes. It is this latter area that causes us concern as we find that a key component in the improvement to social work practice is open to abuse by practitioners. The complaints system in many areas fails in its objective of providing a means of improving practice. Listening to complaints is crucial for developing a more effective child protection system but time and time again we hear that service users, despite our encouragement, refuse to complain to what in our eyes are often valid grounds. A worrying reason that is often quoted to us is that by complaining about their case and parents and carers open themselves up to vindictive actions by those complained about. Unfortunately therefore a very useful method for professionals to learn from bad decisions and improve good practice is lost.

8. Improvements in the way social workers investigate abuse are long overdue and risk management training is required to develop a more open mindset within such investigations.

9. Cultural and linguistic issues have increased in our cases and we have noted a substantial increase in social service interventions involving parents from Poland and the Baltic States. These cases have highlighted to us the lack of understanding by the professionals of the many cultural implications involved which inevitably affects their ability to communicate what exactly is going on—to the extent that we have had cases where parents had little idea of what was happening.

10. Our caseload reflects wide variations across the country and although we have not made a detailed study of the locations it is apparent that a postcode lottery exists and some local authorities appear again and again within our caseload.

Appropriate thresholds for intervention including arguments for and against removing children from their families

11. Thresholds for intervention and the removal of children from families are often inappropriate and as a consequence can do untold damage to the children concerned. Thresholds must be more visible and veer away
from the “grey” as otherwise false positives will increase in number. The rise in cases of alleged emotional abuse over the past decade is a case in point as the lack of an objective definition will mean that some parents will continue not to understand what is alleged. The phrase ‘significant harm’ is also in need of clarification.

12. Research carried out by PAIN some years ago concluded that 88% of allegations of child abuse was “perceived” rather than a direct allegation from a child or empirical evidence of abuse and judging from subsequent cases it is our belief that this level of subjectivity has not changed.

13. PAIN estimates that between 10% and 20% of cases where children are removed from their families are false positives where innocent families are subjected to unwarranted intervention. We believe that there is scope for a much greater use of a fairer and improved child protection conference system to provide a platform for ensuring that only the most appropriate cases go forward for removal of the child.

14. Interventions must be based on evidence and led by research otherwise false positives will keep on increasing and more children will be damaged by the system. The acceptance by more professionals of the need to eradicate the false positive would free up resources to identify and investigate cases of actual abuse. Training and, in particular, input from service users and parent groups like ourselves could be used more extensively to tackle this issue.

Whether the child protection policies and practices of non-social work agencies and government departments assist professionals to work together in the interests of the child

15. It is almost 25 years since the Cleveland Inquiry concluded that there was a serious lack of communication between all the agencies involved and subsequent inquiries and serious case reviews have highlighted this area of concern with the ubiquitous phrase “lessons have been learnt”. This repetition of phraseology is indicative of system that is in need of radical reform and professionals from all camps should stop treating children as an “object of concern” and consider the interests of the child that should include not only protection from actual abuse but from unwarranted protection from the state in removing them from innocent parents or carers. Children and families who have been seriously damaged by an ineffective child protection system rarely get the opportunity to tell their story. Policies and practices of all agencies must be changed to ensure that all children are protected from abuse—both child abuse and system abuse.

16. PAIN understands that the key to reform lies in persuading government ministers to evaluate and “safety-check” the child protection system. As a first step, increasing the checks and rectifying the imbalance in the system would ensure that fewer children are removed from innocent families and therefore more children could be saved from the emotional damage and trauma experienced when wrongly removed from their families.

November 2011

Written evidence submitted by the Association for Improvements in the Maternity Services (AIMS)

1. What We Do

AIMS is an experienced pressure and support group, run entirely by volunteers, which has existed for 50 years. We give evidence to Select Committees and government, are stakeholders in many NICE consultations on medical care, work with the Confidential Enquiries into Maternal and Infant Deaths, and so on. We have links with a number of similar organizations in other countries, and also are active members of ENCA (European Network of Childbirth Associations)

2. How We Became Involved

We run a national help line for the UK, offering support and information to callers and those who contact us by email and post. The changing pattern in these calls often alerts us to new problems before they appear in the medical press or elsewhere. It was in this way that we became aware of an increasing number of calls from parents asking for help when threatened with removal of babies or young children by social services after the previous government set a crude target to “increase adoption numbers”. (The original brief at the Cabinet Office committee had been to look at ‘adoptions and permanence’ for children in care.) This target was reinforced by annual local authority inspections from OFSTED, and there were potentially large rewards attached. For example, Doncaster received over half a million pounds and Essex a million and a quarter for doing so well on their target. We dealt with distressed parents in both areas. Both local authorities were later downgraded to the lowest possible OFSTED rating for quality of children’s services: possibly the concentration on the high-reward adoption target had distorted their pattern of essential care for children.

We believe that the emphasis on adoption has distorted the pattern of care, and has increased parents’ fears and distrust of social services and healthcare professionals and has actually prevented the development of help and support for families in need. Because babies and young children became prime targets, this has had adverse effects on maternity and infant care.

It is not that we are opposed to adoption, when appropriate, (indeed, one of my own children is adopted and we are now besotted grandparents) and is an essential part of the pattern of care for children who genuinely
can no longer remain with their birth parents. Adoption targeting is, however, only one of many problems within the system.

3. PUBLIC IMAGE OF SOCIAL WORK

The Munro Review of Child Protection (April 2011) refers to the “considerable evidence that the child protection system and social workers are portrayed very negatively in the media” and that there is a need to “help the public get a better understanding”. We can only say that this public image has been repeatedly borne out by our own observations and the hundreds of accounts we have received from families, as well as those from newer organizations which have been formed by parents in response to their experiences. Newspaper accounts of families’ bad experiences are invariably confirmed by extensive email correspondence from those with similar stories. Having worked in a local authority child care department in the days when there were properly trained child care officers, I find our case files deeply shocking. It is often even worse than media stories portray. And it is not just a few hard cases; it is widespread. The House of Commons Select Committee on Children, Schools and Families, in its report on Training of Social Workers found social work training not fit for purpose, and agreed with the points we had made in our evidence to them. However, the problem is not quality and training of social workers alone. Even when we observed families’ interactions with social workers who behaved pleasantly and professionally, they too were trapped in the same rigid computerised process, which actually prevented wider understanding and constructive solutions for real problems which some families had. In this we agree with Munro’s recommendations for change. But her recommendations do not go far enough.

4. CONFIDENTIALITY

Because we offer confidentiality to parents (a service no longer available in the NHS, charities in receipt of official grants, and many other support groups like Women’s Aid), we are trusted by those who contact us, and receive a great deal of information which, sadly, is often no longer shared with professional health carers by parents who fear referral to social services. We often have long-term contact with the families who come to us; we have met some of them and visited their homes and met their children, we have been present during social workers’ visits, have attended case conferences and review meetings, and (since we are accepted as advocates) have seen much official paper work, so we do not know only the parents’ side of the story.

5. MISLEADING REPORTS ON FAMILIES

We have observed contacts, and have seen how different descriptions in official reports may be from what actually occurs. These were not just errors or perceptions by individual social workers (of which we saw many examples). Minutes of meetings we attended at social service offices attended by many people in every case misrepresented what had happened. When we asked clients about this, they replied that it was “normal”, and always happened. This implies not just individual, but institutional dishonesty. Many examples from other support groups confirm this picture. It will take more than public relations image building to change this picture in the eyes of the public.

We believe that tape recordings, with copies for families, should be made of all social work interviews and meetings, or that families should be told that they can record for themselves (currently this is frowned on or forbidden, and parents are powerless to refute false evidence given to family courts). In one of our cases a mother videoed her constructive and affectionate contacts with her children at a Contact Centre, which belied social work reports. The judge refused to look at it.

6. VIEWS OF CHILDREN

In some cases we have been privileged to talk with the older children, and learn how devastated they have been by the whole process—particularly when they have been separated temporarily from a sibling or half-sibling. This major bereavement, which often has serious long term effects on their behaviour and school work, has received little understanding or recognition. In most of our work involving babies and younger children, we observe body language, which can speak volumes, but seems to be one in which social workers are not trained. In some cases we can speak for the children who as yet have no voice—the unborn, the infants and the youngest children.

7. WHERE IS THE EVIDENCE OF BENEFIT?

Most of our work has been on maternity care, and we are used to reading and assessing evidence, and looking at a range of outcomes, whether adverse or beneficial. What was immediately deeply shocking to us was the lack of research on effects of social work intervention. There were virtually no randomised trials—the gold standard of research. Yet local authorities were using often poorly trained and sometimes unqualified social workers to intervene in the lives of thousands of families, and to set in train a series of expensive interventions with no evidence on outcomes. No expensive medical intervention would be allowed this level of expenditure at the taxpayers’ expensive without evidence that benefit outweighed harm. The only harm which was widely emphasised and publicised, was the concern for children not removed in time to prevent a tragedy—eg Victoria Climbié, Baby P, and so on. Everyone was drawn into the net—social workers, midwives,
health visitors, GPs, teachers, council house repair workers, charities receiving grants. All had only one aim in practice: to “cover their backs” by not missing a case, resulting in many unnecessary referrals—and we see the adverse effects in our calls and postbag every day.

Since we study sociological as well as medical research, we are well aware of difficulties in researching “grey” areas. But it can be done, as we shall show, (see para 18) and it is not only unethical NOT to seek answers before sundering or harming thousands of families, it is indefensibly wasteful of public money.

8. THE NEED TO MEASURE OUTCOMES

It seemed that there was not just lack of knowledge: it is as if there was an unspoken agreement not to seek or record adverse effects. The adverse effects of ‘false positives’ in medical tests and screening were very familiar to us. However, in child protection it seemed that an unlimited number of children and their families could be damaged by false positive identification and intervention, and no one asked How many? What ratio is acceptable to society? What are the outcomes for families?

9. VOICES OF CHILDREN—AND PARENTS TOO

There has rightly been emphasis in recent years on voices of children in the process (though a number of children have bitterly complained to us that their messages are only accepted if they are saying what the social worker and CAFCASS officer want to hear. One older sibling decided to tape record her interview with a social worker, which showed repeated attempts to persuade her to make hostile comments about her mother, her sole carer since birth). There is room for infinite distortion in the process of transmitting those voices through the courts, and children do not see what is eventually written and said. Parents do—and frequently challenge, and produce proof, that there are many distortions and inaccuracies. But they have the lowest status in the process. They must have been found wanting as parents, the proof being that social services are involved with their family. Even when they are trying to transmit important messages about safety of their children, or their essential health needs, their voices are ignored. (AIMS submission to House of Commons Select Committee on Children, Schools and Families on Looked After Children) Parents are disempowered in order that the State can take power, and “children’s voices” are used as an excuse to exclude theirs. Yet the Sure Start research has shown that it is empowering parents which proved to be the most effective tool for improving parenting. (F Williams & H Churchill Empowering Parents in Sure Start Local Programmes HMSO 2006).

10. EARLY EVIDENCE OF HARM

We were so concerned at the picture which was emerging, that in 2007, after analysing our first 50 cases, we wrote to Chief Medical Officer in England on the Adverse Effects on Public Health of Child Protection. (attached) We were seeing long term trauma to families who had been investigated even briefly, babies taken into care being denied breast milk despite its many proven benefits, women now afraid to report domestic violence or pregnancies resulting from rape for fear of being reported to social services and losing their children, concealment of postnatal mental illness for the same reason despite the fact that postnatal suicide was the largest single cause of deaths associated with childbirth, increased marital breakdowns after such intervention, and so on.

11. STRESS DAMAGES THE UNBORN CHILD

All these problems continue and even more worrying data has emerged. Severe stress in pregnancy which causes anxiety has been shown to have independent long term adverse effects on the health and behaviour of the child after birth, and these effects continue into adulthood. (V Glover, T O’Connor Effects of antenatal stress and anxiety: implications for development and psychiatry Br Journ Psychiatry 2002 180: 389–391) We are, of course, used to working with mothers whose pregnancy is stressful for many reasons, but the stress for both parents in cases where social service referral is threatened or actual during pregnancy is as bad as, and often worse than, anything we have worked with before, and is, of course, prolonged into the postnatal period.

12. SCREENING FOR POTENTIALLY HARMFUL PARENTS

All pregnant women are now routinely screened for supposed “risk factors” to their unborn child, and positive identification is likely to result in referral to social services, or the threat thereof, despite the fact that there are no studies as to whether this improves outcomes for the pregnancy, the birth process, or long or short term on the child and it is known such screening will create many false-positive cases. Yet research now shows that the anxiety created in the mother is almost certainly doing more harm to the unborn child than that which the mother may be at risk of causing later. An alternative approach would be to provide supportive and caring services for all pregnant women suffering any outside cause of stress, and not to add any further cause for anxiety. This is one of many examples where child “protection” aimed at identifying parents as potential abusers (the ‘witch-hunting approach’, as our clients call it) rather than offering truly supportive services, is doing more harm than good, and is damaging children even before birth permanently and seriously to a greater degree than the mother might do.
13. LACK OF KNOWLEDGE OF MATERNITY CARE

Even experienced social workers know little about pregnancy, childbirth, breastfeeding and the sensitive time and needs of parents in the postnatal period. (AIMS written evidence to Select Committee on Children Schools and Families on Training of Social Workers) We have had many examples where their ignorance has been damaging (eg a nervous mother near term with her first child traumatised by the social worker who told her the pregnancy could be outside the uterus; if true, she would have made medical history). Yet they blithely intervene with prescriptions for what the mother must do to show she is compliant and satisfy their criteria if she is to keep her baby. They have even issued dangerous medical instructions and advice in several cases. The problem is compounded by the fact that while local authority Safeguarding Teams include a nurse, they do not include a midwife, and we have had cases where the nurse’s ignorance of maternity care, and assumption that she knew things which she did not, led the team seriously astray.

14. LACK OF TRUE SUPPORT FOR PARENTS AND FAMILIES

On many occasions we have seen cases where families in genuine need of help are longing for truly supportive services, but they do not exist. We have seen too many cases where a simple request for what we see as legitimate help has led to parents who had openly asked for constructive help had been tramlined into the only pattern of response which now seems to exist—the punitive and damaging labelling of parents as inadequate or dangerous, and threatened or actual removal of all or some children. We have seen a number of similar cases highlighted in the press, and this risk is now well known in communities, and serves as a warning to others. Whilst the Munro Review recommends an increase in supportive work—increasing the size of the carrot—the stick is to be moved just a little further into the background. We believe this change does not go far enough.

15. HEALTH VISITORS

Because of their enhanced role in child protection, Health Visitors are now widely known as “the health police” and increasingly mistrusted. We know, from our many calls on the subject, how often they are actually deterring families from consulting them about real problems, and how they increasing distrust of official services. The Munro Review calls for expansion of the service. We believe that restoring trust and confidence in their work will be a long and difficult process. They too have unquestioningly accepted recruitment into a rigid, damaging system, which as professionals they should have looked at more critically. And midwives are now going the same way.

16. RISKS FOR FAMILIES WITH DISABILITIES

These unmet needs are particularly apparent in families who have a parent, or one or more children with chronic disabilities. Because they become unpopular with local authorities for demanding expensive services or educational facilities which are in short supply, and they also are in frequent contact with health services where they also have often to act as patient or child advocates, they may be at particular risk of damaging and unwarranted social services intervention. In their cases, threat or use of child protection procedures is a means of exerting power, gaining control, and ensuring compliance.

17. SOCIAL SERVICES AS A MEANS OF CONTROL

We are seeing an increasing number of cases where referral to social services is seen as a means of controlling or silencing pregnant women or parents who are seen as asking for services an individual health worker or teacher does not want to provide, which may be legitimate but inconvenient (eg women who want home births, or to avoid repeat caesarean sections), or who refuse recommended treatment—inevitably for good reason. Social workers and some midwives and doctors seem to be unaware that coerced consent is not legally valid. Also we, and other consumer groups, have seen a number of cases where child protection referral has been used maliciously in an attempt to silence parents who have made a justified complaint about a midwife, doctor, health visitor or teacher. The adverse effects of this have been so severe in a number of families, that we, one of the most experienced organizations in the country in dealing with health care complaints at every level, are very wary indeed of advising clients to complain once any social services intervention is remotely possible, or to complain on their behalf ourselves, despite the fact that some involve serious issues of public safety.

18. A DIFFERENT WAY

Fortunately, on the other side of the Atlantic, effective and impressive research has taken place. At last someone was using the gold standard to study outcomes: a large scale randomised trial. In Minnesota, after exclusion of cases where children appeared to be at immediate and serious risk, over 5,000 families referred for social work investigation were randomly allocated to either the standard process—like ours—of seeking out damaging and dangerous parenting, or to an Alternative Approach, which was supporting the families and trying to obtain help they needed. The families were followed up for an average of three and a half years. An Executive Summary of the Minnesota Alternative Response Evaluation by L. Anthony Loman and Gary L Siegel and is available at http://www.larstl.org/papers/FinalFRAReportExecSum.pdf and the full report is
ADVERSE EFFECTS OF CHILD PROTECTION ON PUBLIC HEALTH

You may recall that we sent you our analysis of our first 50 or so child protection cases when you first started looking at problems with medical expert witnesses. We read your most helpful document on supply and training of expert witnesses with interest, and responded to the questionnaire, and have seen your brief summary of responses. We are now preparing our second round of comments as NICE stakeholders on diagnosis of child abuse (greatly concerned, incidentally, at the truncated definition of the amended scope).

Medical opinions, however, are but a part of the system which impacts on children and parents. We are now so concerned at the adverse effects of child protection procedures in the UK that we felt we had to write to you. As a group which runs a national help line, we are seeing how serious, long-lasting and widespread the adverse effects of these expensive interventions are. Since, as advocates, and occasional Family Court witnesses, we see many case and court files, we know how questionable and inaccurate the allegations, interpretation and documentation from which many investigations spring are. Sometimes it is unclear where harms and benefits to children and families are outlined on pp 66–68 of the full report, which is published by the Institute of Applied Research in St Louis Missouri. What struck us immediately was the similarity of adverse effects from the current approach to those we had seen in our own cases, which now amounted to hundreds. Anecdotal evidence however, does not impress policy makers, but well-designed, large scale, trials with long-term follow up, cannot be ignored.

(a) The percentage of families who felt more able to care for their children had declined with the standard approach, but increased in the supportive Alternative social work. This exactly fitted the picture of the many parents who told us that they were less confident in coping with their children than they had been before they had had even short-lived contacts with child protection processes.

(b) Economic stress had also increased in families subject to standard social work—again confirming parents’ accounts to us.

(c) Children in families who had traditional social work had had more serious illness than before social workers intervened, now had increased days off school from illness, complained more often of being unwell, had more trouble than before in learning at school, were more likely to refuse to go to school, were more likely to seem depressed, were slightly more likely to be difficult to control and more likely to engage in delinquent behaviour.

(d) Children in families who had Alternative social work had less serious illness than before, fewer had trouble learning at school and they got on better with other students, and were less likely to engage in delinquent behaviour and were slightly less likely to be difficult to control. Rates of missing school through sickness, school refusal, and acting depressed were unchanged, and complaints about being unwell had increased. As the authors point out in their summary table on p 68, “the direction of the change was persistent across items, always a little worse for the children in the control group and a little better among children in the pilot”.

This confirms the picture we have seen over and over again in our families, and from accounts reported by other consumer support groups. The official approach has been to identify bad and dangerous parents (though some will always be missed under any system) and to remove their children at the earliest possible age, when adoption has the greatest chance of success, or to “re-educate” parents. The standards as to what is acceptable parenting—which in our experience vary from social worker to social worker, area to area, and of course over time—are not publicly discussed, and the public for the most part have no idea what is being done in their name. Those who make the observations and judgements are woefully undertained and under-equipped for this task. We know that many previously normal, affectionate parents and their children have been deeply damaged by the current investigative process, and far more seriously than the Loman and Siegel studies show. As for families who already had problems and needed constructive help, they did not receive it, and all emerged worse than before. Children removed as babies and adopted will, we hope, be flourishing, but there are likely to be future problems for them and their adoptive parents when they seek out their origins.

20. CONCLUSION: DOING HARM TRYING TO DO GOOD

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APPENDIX

Letter to Chief Medical Officer in England

ADVERSE EFFECTS OF CHILD PROTECTION ON PUBLIC HEALTH

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the trail began, and a surprising number seem to start after justified consumer complaints have been made about health care or other staff.

When instructions went out to all staff in contact with children to report concerns about risk, this seems to have been done with little prior thought, without consultation, and without provision for training. The result was the post-Climbié cover-your-back syndrome: “when in the slightest doubt, report to social services.” We see a huge variety of standards, misunderstandings, prejudices, ill-informed interpretation of risk factors, cultural incompetence and even racism, in the initiation of cases from health visitors, teachers, midwives, nurses, doctors and others. Quite apart from the damage to families, each one of these reports pre-empts resources and often leads to substantial, and unnecessary, cost. Ironically, the basic, simple help or real support families would like, is unavailable because resources are lacking, that is not the focus of social work activity, and anyway nowadays many parents are afraid to ask because any contact with social services is too risky.

Community information grapevines work, and effectively circulate information about what people see as the growing risk of being investigated or labelled as a dangerous parent after contact with medical care. The risk is not merely perceived: it is real, and the consequences are devastating. Damage to the whole family structure (sometimes the extended family network and its support structure), to parental confidence and self-esteem, to children’s sense of security and safety, and their sense of security that their parents can and will protect them—these are very serious adverse effects. Often we find it is the most sensitive parents, to whom family life means everything, who are most damaged. We also have many concerns about damage we have seen to authority of black parents vis-a-vis their children, many of whom are already coping with multiple racial prejudice problems. As we have pointed out to NICE as stakeholders in their consultation of diagnosis of child abuse, such potential for harm must now be considered, and it is long overdue. The sheer cultural incompetence of many social workers has to be seen to be believed.

The following list is not exhaustive, but gives examples of typical problems. We make no claim for their being representative of the whole picture of child protection activities, of course, since we deal only with those who come to us for help. However, the problems we find seeming to be echoed by other groups.

1. FEAR OF ACCESSING MEDICAL CARE

Nowadays parents call us and ask for advice when their children have accidents, because they are afraid to go to A & E, and they know we run a totally confidential service. We cannot give such advice as we are not qualified to do so. We have been in existence for well over 40 years and can recall no such requests until about four years ago. There is now no health professional, or official help line, parents feel they can safely ask for help. All agencies, including NHS direct, will report anything they regard as suspicious. Innocent parents, who have had one brush with the system, or social services investigation, or whose friends, relatives or neighbours have, now find the risk of avoiding treatment preferable to the risk of damage to the whole family of going for help.

2. DISTRUST OF HEALTH VISITORS

Mothers are opting out of seeing health visitors, and are advising friends not to see them, after they, or someone they know, has had a similar encounter. Those who feel obliged to do so, tell them as little as possible. One incident and they tell us “I’ve made sure everyone in the village knows not to trust her.” In some areas, however, merely opting out of seeing a health visitor (maybe because they don’t like her, or find her advice or manner unhelpful) is cause for referral to social services in itself—thereby confirming the increasingly common perception of them as the “health police”. Those who do see the health visitor are highly circumspect about the information they give.

3. ADVERSE EFFECTS OF MEDICAL INVESTIGATIONS

Small babies with a tiny bruise are automatically given whole-body X-rays at an early stage. (“Those who don’t cruise, rarely bruise”—“rarely” being interpreted as “never”). The likely cause has sometimes proved to be equipment such as a baby-carrier or push-chair. Sometimes a boisterous older sibling—a toddler—is suspected but this cannot be proved. The parents, not unreasonably, are now continually worried about the future possibility of leukaemia. As these whole-body X-rays are now so common, (there should be a database of such exposures) the likelihood of this in some children must be increasing.

4. CONCEALMENT OF POSTNATAL MENTAL ILLNESS

As at least two studies have shown, mothers are lying in response to the questions on the Edinburgh Postnatal Depression Scale and they are concealing post natal mental illness, for fear of social service intervention. We knew this from our help line, long before the research appeared. A formerly useful, validated, screening tool no longer works. This is alarming since suicide is the largest cause of deaths associated with childbirth. We are dealing with seriously ill women, and we know that contact with child protection services only worsens their state but it is as if no-one cares. One immediately suicidal mother was told by her GP “We don’t have to worry now: the baby is safely in care.” Everyone concentrates on safety of the baby, though statistically the chances of the mother killing herself are very much greater.
The known serious long-term adverse effects for a child of losing a parent through suicide are not even considered. We seem to be the only remaining group who see mother and baby as a dyad, and think they need to be treated as such. The Confidential Enquiries into Maternal Deaths report cases of suicide which are directly related to women's fear of social services taking their children—real or imagined—and points out what a large number of children have been orphaned by post-natal suicide. These suicides are, of course, only measured for the first year post-natally, but we have clients at risk, and know of cases, long after that. We have many cases where social services intervention is intensifying and prolonging the very postnatal depression which they are seeing as the reason to take their babies. We have never yet seen a case where the mother found social worker intervention helpful or supportive. In the last fortnight I have worked with two women who I feel are suicide risks (one acute) solely as a result of social service management. As their babies are now over a year old, their deaths would not be included in the statistics, but we are prepared to give evidence to coroners if the worst happens.

There are no Paternal Death statistics. Naturally postnatal mental illness in mothers is our major concern, but we are hearing of more and more cases of fathers tipped into depression by child protection investigations. The intervention itself is frequently toxic to mental health, and greatly damaging to self-esteem, which is particularly important where it is fragile to begin with, or families are already dealing with racism.

5. LOSS OF BREASTFEEDING

Many mothers whose babies were precipitately removed, (they, and we, suspect as potential adoption material to meet targets) but had to be returned when a case could not be made, grieve for the loss of breastfeeding, with its long term benefits for mother and child, and for the damage to bonding. If and when children are returned, they are unable to re-establish it. One woman recently told us of the profound difference in feelings towards her two children, the first of which was affected by child protection actions and threat of removal, and the second, which had a happy normal birth. It is a story we have heard from a number of others. Even the threat of intervention or suspicion can cause serious damage in the sensitive postnatal period, and we have vivid descriptions from parents.

In a number of cases mothers have expressed breast milk and begged social workers to give it to the baby, and they have refused. Others have not openly refused but mothers later discovered it was thrown away. One baby (an adoption target) was recorded by a paediatrician as “bottle fed from birth” though all the notes clearly indicated otherwise. More recently some breast feeding mothers have been asked to express milk by social workers (we suspect as a result of European Court human rights decision on one of our UK cases P, C and S v UK 16 07 02). They dared not refuse since it might lessen the chance of the baby’s return, but firstly this is often very difficult for the inexperienced primigravida, and the continued lactation (and oxytocin levels) added to their distress at the baby’s absence (a price all lactating mothers pay). It was not a choice those particular mothers would have made. In some cases the stress has caused lactation to fail totally, and the mother is further devastated. This is NOT a case that social workers are “damned if they do and damned if they don’t”, but that their ignorance and the way they use (and mis-use) information to strengthen their case often works adversely for both mother and child.

6. INCREASED USE OF ALTERNATIVE PRACTITIONERS

After a brush with the system, more families in our files are avoiding orthodox medical care and increasingly turning to alternative practitioners for their own, and their children’s care. Whilst many parents are full of praise for the alternative practitioners they use, we have concerns about lack of paediatric and medical knowledge. I have never forgotten interviewing the mother of a young child who died from diabetes when parents followed such advice. Parents with ongoing medical problems are also foregoing care for themselves because they no longer trust the system.

7. MORE CHOOSE HOME SCHOOLING

An increasing number of children in our files are being removed from school and are home educated, sometimes after a fairly minor brush with “protection” services, because the educational system (including nursery education) is now seen as part of the surveillance process, which can be influenced by the whims, prejudices and occasionally hostility of individual teachers. Another child was removed by nursery school because the teacher there was questioned by social workers about the parents and is no longer trusted, so it is at home.

8. MORE SEPARATIONS AND MARITAL BREAKDOWN

We have lost count of the number of marriages and partnerships which have broken down as a result of the intense stress caused by child protection investigations of what turned out to be innocent parents. The children now have an absent father and are largely cared for by the traumatised mother. This loss alone is far more damaging to the child than the potential harm of which parents were initially accused.
9. REDUCED PROSPERITY AND WELL BEING

We have been surprised to see how often families suffer considerable financial loss and are in reduced circumstances because of intervention. This includes both the poor and the middle class. The stress, and time-consuming nature of trying to fight their corner, takes all their time, and often erodes their health. There is no longer time, or money, to take the children on outings they would once have had, for example. Making photocopies, postage of documents, paying for copies of their records and faxes, and so on, eats into the limited resources of those who have little to spare. Some are prevented from pursuing former careers where local well-circulated, and unproven, suspicions have made them unemployable, yet there is not a shred of evidence that they are unfit.

When social services depart and have closed the files, the family may well have turned in on itself. Sometimes they have felt they could not talk about what is happening to neighbours, friends, or even relatives. Sometimes they fear stigmatisation. Sometimes they are stigmatised. Garbled, distorted stories may have been circulated in schools, clinics, churches, etc. Contact with friends, neighbours, clubs, even relatives, may be reduced sometimes drastically. Their social capital—known to be an important factor in mortality and mortality—has been reduced.

10. LACK OF HELP FOR THOSE IN NEED

Parents whose children have behavioural or educational difficulties now feel there is no confidential, trustworthy source of help they can go to. It was sometimes those very difficulties (then undiagnosed) which led to the interventions, but when everyone else goes home, the parents are left to cope with them, often now worse than they were before, but with nowhere they can, or dare, turn to.

Parents who cannot avoid the system, because they have disabled children, find themselves in a continual weary battle to preserve their sanity, their integrity and their self-esteem. There is a lot of black humour in our telephone calls: we agree they are “the lucky ones” in that their children are so seriously disabled, social services and doctors don’t want to take them (they would be too expensive and risky to keep in care, and are not seen as adoption material) but the perception is that professionals just want to exert power and control everything they do, rather than listening to parents who have found out what works and helping them with basic, simple needs.

Because we run a totally confidential service, and never report anyone to anywhere, we are told a great deal which would be helpful to professionals involved with family care, but which they will never know because now all are required to report suspicions, so none of them is trusted.

11. CONCEALMENT OF RAPE CONCEPTIONS

Women whose pregnancies are the result of rape are not mentioning this to anyone, though they are desperately in need of support and sensitive care, for fear of social service interference. We are supporting them as best we can, especially since we saw the disastrous effects after a woman confided in her midwife, who reported to social services in another case.

12. CONCEALMENT OF SEXUAL RISK

Parents who have had a brush with the system withdraw from being part of the watchful community group which helps to protect all children. For example, a number of them have told us about sexual activities of quite young fellow pupils at their children’s school (which now seem surprisingly common) or grooming attempts by local paedophiles. Whereas at one time they would have acted, now they keep quiet in case any activity re-awakens interest in them or their children. They are no longer willing to try to protect other people’s children: they have pulled up the drawbridge. In view of the number of cases we have seen where women who reported paedophiles and ended up being disbelieved or vilified themselves (the assumption that these genuinely concerned mothers were making it up for their own ends, in custody battles etc) we do not blame them.

13. CONCEALMENT OF DOMESTIC VIOLENCE

Women who are suffering domestic violence are continuing to conceal it for the same reason. Since we have seen cases of babies removed from such women, even after they have left their violent partners and are coping well, we are not surprised.

14. CHILD PROTECTION AS SOCIAL CONTROL

Use of child “protection” or threats thereof are increasingly being used to control parents who are seen as unorthodox, or not completely compliant. (The social worker’s ideal “compliant” mother does not seem to be one who would have the personality to insist that other people don’t smoke near her baby. Yet “stroppy” mothers can be advantageous to children, protecting them when they live in difficult social circumstances. Heaven help the disabled child or one with special needs who does not have at least one stroppy parent to fight for him). The message is getting round quickly, and parents are opting out of official sources care even more, or being even more selective on what information they give, and what they conceal.
15. TOXIC PSYCHIATRIC LABELS

Your recent report confirmed the picture we have from our cases, that psychiatrists greatly outnumber paediatricians as court experts in Family Court cases. Selected experts are invited by social workers to confirm that the parent who complained about the health visitor, or who has criticised or challenged them must have a “personality disorder” (not uncommon); this has now replaced the rather discredited Factitious and Induced Illness (frustratingly rare) as the method of choice. Judges do not ask the simple question: what is the baseline of this in the community, and are we to remove the children of all such parents? Where is the evidence that this child is, or has been, at risk from this parent?

The result is that many parents and children, even if not separated and found guilty of no harm, have now acquired permanent damaging labels—widely circulated among shared records—which they, and we, suspect are likely to be a permanent source of prejudice, which do not contribute in any constructive way to their care, support, treatment or interaction with services. Since the condition is widely regarded as untreatable, there is no responsibility on the psychiatrist or the NHS to treat, but there is total freedom by lay and medical personal to disregard what the parents say.

There is a substantial literature on the effect on professional attitudes of any label such as “personality disorder”, for example, and how it affects attitudes to the patient and hinders diagnosis and prevents treatment. Yet many families are acquiring these labels as a result of totally unjustified intervention in the first place. In many of our cases specific psychiatrists and psychologists seem to have been called in when social workers were unable to find evidence to prove the case they wanted. Despite our strong suggestions to clients that they should obtain copies of the psychological tests carried out on them, so that conclusions may be challenged, and their validity for different cultures assessed, so far no-one has managed to do so. (Incidentally, we are also concerned at the number of cases where these same professionals then go on to recommend to the court that the family needs exclusive private treatment by themselves at a cost of many thousands of pounds.)

As with paediatricians and Munchausen Syndrome by Proxy, experts who are knowledgeable, are seen as unbiased, and will give evidence if the parent is as scarce as hen’s teeth. When a child has some physical problems, there is hope that the truth that the mother was not wrong in believing her child to be ill, will emerge eventually, through advances in medical knowledge, or even at post mortem. With psychiatric opinion of a parent’s state at the time, what hope is there of rebuttal? The MSBP label carries its own unique trail of damage: anything the mother reports to any authority is not believed—or rather is automatically disbelieved, by doctors, teachers, the police etc, and we have seen cases of actual endangerment because of this.

Medical opinions can be wrong. Has everyone forgotten that once all the paediatricians and health visitors were ordering mothers to place their babies face down to sleep? We know a number of older mothers who did not “comply” with that—they just liked to watch their babies’ sleeping faces. And maybe some of their children were saved from cot death as a result.

I could go on. But you can see why we are so concerned. Unless both professionals and the courts understand how common, and how serious, the adverse effects of child protection intervention and investigation can be, how can they balance the risks of action versus leaving well alone?

November 2011

Written evidence submitted by Magistrates’ Association

(i) The Magistrates’ Association, representing the 7000 magistrates who sit in the Family Proceedings Court and deal with the majority of the public law Children Act work and a substantial and rising proportion of the private law work, welcomes this opportunity to make representations to the Committee in response to their inquiry into the child protection system.

(ii) We support the need for early identification of problems in families through the child protection system so that appropriate and professional support can be given to vulnerable children to improve their wellbeing, whether this be by focussed work within the family setting or through the care system if removal is the only option. If there was more effective work with families we believe that fewer children would become the subject of care proceedings. We base this on the United Nations Convention on the Rights of the Child and the Human Rights Act and the view that the risk of significant harm has to be such that that removal from a child’s birth parent/s is the only tenable way to protect that child from future harm and to offer them better life chances.

(iii) We support the aims of the Munro Report in complementing the work of the Family Justice Review in improving the quality of social work practice in bringing forward Section 31 applications where necessary. We support the aims of the Family Justice Review in reducing delay in care proceedings such that decisions about children’s futures are made within their timescales rather than those of the system.

(iv) We welcome the announcement that the Children’s Workforce Development Council (CWDC) is allocating £8.5 million funding on behalf of the Department for Education to help local authorities implement recommendations from the Munro Review of Child Protection and acknowledge the vital specialist support work that it will provide to help local authorities find workable and sustainable solutions to address the recommendations.
Ev w84 Education Committee: Evidence

TERMS OF REFERENCE

1. Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

Neglect and emotional abuse

(i) Magistrates are faced on many occasions with cases of neglect where there has been an extensive chronology of a referral being made, some work being done then the case being closed and for this pattern to repeat itself several times over a period of years and eventually for care proceedings to be sought. During this time children may be bullied at school, may have poor school attendance, may exhibit other behavioural problems where the parent/s fail to engage with services. Olive Stevenson raised the concern that the child protection system was incident-led rather than taking a holistic view looking at patterns of behaviour to assess neglect. Nina Biehal in the study (2011) Caring for Abused and Neglected Children: Making the Right Decisions for Reunification or Long-Term Care by Jim Wade, Nina Biehal, Nicola Farrelly and Ian Sinclair (University of York) says that she was shocked at how long some of the children in the study had been left at home in appalling circumstances, particularly in relation to emotional abuse and neglect. They found that most children had a relatively long exposure to harm before becoming looked after, had experienced multiple forms of maltreatment and a high number of other adversities.

“At this stage there is a need for decisive early intervention and provision of services (identifying written goals, timescales and consequences) in order to support families, and speedier decisions to reduce the likelihood of further damage to children.”

(ii) There is abundant research, some of which is quoted by Munro, that significant harm is caused at an early stage of a child’s life to their neurological and development pathways if the causes of the distress are not dealt with. One example given by one of our members is the work of Dr Aileen Naughton, Designated Doctor, Safeguarding Children Service, Public Health for Wales:

Effects of removing neglected children at various ages into alternative care but no additional services

(Dr Aileen Naughton)

<table>
<thead>
<tr>
<th>Age at removal</th>
<th>Recovery Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>Significant recovery</td>
</tr>
<tr>
<td>2nd year</td>
<td>Some recovery, but less</td>
</tr>
<tr>
<td>3rd year</td>
<td>Less recovery</td>
</tr>
<tr>
<td>4th year</td>
<td>No change (100% need SEN and public funding ++)</td>
</tr>
</tbody>
</table>

Munro reinforces the need for:

— timescales in the identification of children’s needs;
— quality assessments to inform the next steps; and
— effective help to be provided.

We support this analysis and hope that the Family Justice Review’s final report will address these issues.

(iii) Physical abuse and diagnosed sexual abuse

Where these concerns are raised, it is our experience that there is prompt action to address these issues for the children concerned. However there is more need for training for social work staff in identifying sexual abuse, eg what happened in Derby children’s homes where the sexual abuse of children in care was not picked up until the police identified the abuse.

(iv) Domestic violence

Dr Pamela Towner (2007) has identified the significant harm caused to children where there is domestic abuse in the family: poor attachment, poor neurological functioning, post traumatic stress disorders. The police are key in informing social work staff and health visitors about incidents where children are present, however from case notes and chronologies seen by magistrates it is apparent that not all cases are then followed through as the threshold is set too high, effective and preventive action is not taken and more damage is done to the children in the meantime.

(v) Forced marriage

Magistrates do not deal with these issues, they are sent to the designated Care Centres.

(vi) Female genital mutilation

If action needs to be taken then this is an issue again for designated care centres
2. Factors affecting the quality of decision-making in referral and assessment, and variations across the country

(i) Please see above regarding neglect and emotional abuse and domestic violence. From magistrates’ experiences, the submission of the Magistrates’ Association to Munro and the University of York report it is clear that thresholds vary across the country. Munro spells out that coordination between agencies working with families is vital but that there is lack of clarity about how to manage and share information, and what the boundary is between what is safe for a child or young person and what has become too dangerous and harmful. Magistrates see evidence for this confusion in the chronologies presented to them in case files from the perspectives of the professionals working for different agencies such as health visitors, teachers and social workers.

3. Appropriate thresholds for intervention, including arguments for and against removing children from their families

(i) We note that that family proceedings courts do not use a separate criteria when considering “thresholds for intervention” but rely on those used by local authorities/police and then consider these in relation to any challenges which are made in courts.

(ii) We consider there is not an appropriate threshold to determine whether neglected children on child protection plans should be removed from their parents. The length of time they are on plan is not monitored by Independent Reviewing Officers.

(iii) The threshold used by police officers when taking a child/children into police protection need not be tested for 72 hours by a court. The decision to remove by a police officer is at the police officer’s discretion.

(iv) There has been much recent discussion about the value and appropriateness of removing children from their birth parents, witness the remarks of Martin Narey and the ensuing correspondence. The University of York study makes the case from their research for neglected children who have been removed to remain in care:

“Although the care system is rightly criticised for its weaknesses, this study has shown that for many maltreated children it can provide an opportunity for children to feel safe, to re-shape their lives and take advantage of opportunities that had previously been closed to them.”

(v) We fully support the primacy of the family in bringing up its children with all the necessary support from the local authorities but where families fail their children then the primary concern is the welfare of the child as spelt out in the Children Act., not the welfare of the parents. We are not convinced that the evidence magistrates see before them daily in court demonstrates this principle consistently in practice. The decision whether a child is to remain with its family or be removed must be for the court having regard to all the circumstances.

(vi) One major concern of magistrates is whether parents always fully understand the reasons why care proceedings have been brought and what they have to do to demonstrate to the local authority, the guardian and the court that they can provide adequate parenting. A related matter that can be the cause of significant delay (and delay is always regarded as likely to be prejudicial to the child’s best interests) is a late application for members of the wider family to be assessed as potential carers. It is important therefore that a family group conference is held at an early stage to ensure that family members do not hang back out of perceived loyalty to the birth parent/s.

(vii) We would support research into the effectiveness of the letter before proceedings and its timing in making an impact on parenting. We heard recently from Anthony Douglas, Chief Executive of Cafcass that a pilot project in the Midlands involving guardians at the pre-proceedings stage was showing good results.

(viii) Before a case comes to court, it should be clear what assessments need to be done, what the timescale is for the child and whether parallel planning (including adoption or special guardianship) is appropriate in which case the relevant local authority decision making panels should be booked to avoid delay. Courts should be able to expect that such assessments will be part of the initial filing bundle in the vast majority of cases, and that the guardian (able to engage fully with the issues of the case from date of appointment) will provide an independent view of the local authority case and timescales at first hearing.

(ix) One of the reasons that cases have come to take longer once in court has been the growth in expert assessments. While there are cases where these undoubtedly assist the court, magistrates have become increasingly concerned with what we might call the “multiple children” cases. These are where we are faced with parents who will have already had several children permanently removed from their care and where on the facts there has been no significant change whatsoever in the behaviours, usually but not exclusively associated with chronic substance abuse, that lead to the removal of their children. Then along comes the fourth or fifth baby, proceedings are instituted and an application made to the court to order further assessments by one or more experts, for example psychologists or Independent Social Workers. We think it is only right that magistrates are prepared to critically examine and challenge such applications particularly where granting of them would adversely affect the child-focussed timetable already in place.

(x) Where there are disputes about assessments then the following appeal before Sir Nicholas Wall, the President of the Family Division, Lord Justice Moore-Bick and Lady Justice Black is relevant (22 June,
reported 15.07.11—b4/2011/1004/fafmf—[2011] ewca civ 812 where an appeal against refusal for a 38(6) application for a residential assessment was refused. One of the grounds was the welfare of the child and the detrimental effects to the child of the delay involved. Re B was quoted where Baroness Hale judged that “in many cases the local authority and the guardian should be able to assess the situation and that further or other assessments should only be commissioned if they can bring something important to the case which neither the local authority or the guardian is able to bring”. Sir Nicholas Wall also stated that “This court has of course stressed the importance of the hearing of the care proceedings being fair, being Article 6 compliant. However, it is not necessary, for that purpose, to continue to assess parents if the process is not going to contribute anything to the information that is needed for the ultimate decision.”

4. Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

   (i) This section is outside our competence.

   November 2011

Written evidence submitted by the Coram Children’s Legal Centre

A. Introduction

1. Coram Children’s Legal Centre (CCLC), part of the Coram group of charities, specialises in law and policy affecting children and young people. CCLC provides free legal information, advice and representation to children, young people, their families and carers, and professionals, as well as international consultancy, research and policy work on child law and children’s rights.

2. The Centre’s family law department works in the area of child protection, and represents parents who are undergoing child protection assessments, court proceedings or children who are looked after by their local authority. We deal with cases in which there has been a failure in child protection systems, and in which children have been unable to access the necessary support and services to which they are legally entitled. The CCLC has also recently established a Child Protection Project, which provides legal information, advice and training by telephone, online and in-person to non-legal professionals who work with children and young people. The CCLC’s work also includes specialist legal and policy work with children subject to immigration controls and seeking international protection, including trafficked children. We are able to draw from our experience in working with parents, carers, children and professionals to provide evidence, and we welcome this opportunity to provide evidence to the Education Select Committee for their inquiry into the child protection system in England. We have limited our evidence to those key issues that are most relevant to our expertise and experience.

3. CCLC currently chairs the Refugee Children’s Consortium—a group of NGOs working collaboratively to ensure that the rights and needs of refugee children are promoted, respected and met in accordance with the relevant domestic, regional and international human rights and welfare standards. CCLC fully endorse the evidence submitted to the Committee on 4 October 2011 by the Refugee Children’s Consortium.

B. Does the child protection system allow for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)?

4. It is the view of Coram Children’s Legal Centre that improvements should be made to the current child protection system to ensure that all children at risk of suffering different forms of abuse and exploitation are properly and promptly identified. Our experience from representing parents within care proceedings is that it is sometimes difficult for those working with children to identify when a child is suffering or is at risk of suffering abuse. Identifying risk is particularly difficult in cases of emotional abuse and/or neglect, where the signs of potential risk can be very subtle. Due to the difficulty in identifying the risk to a child, delay in considering and implementing protective measures can ensue, causing further harm to a child.

5. It is essential that all “front-line” professionals who work with children be given rigorous and continuous training in relation child protection and safeguarding; in particular regarding the identification of all forms of abuse and exploitation. Relevant institutions should ensure that a sufficient budget is allocated to training members of staff who work with children and are in a position to identify and report signs of possible exploitation and abuse.

6. Training to front-line professionals should also be provided in the environmental factors that can increase the risk of abuse and exploitation. In our experience, identifying risk of abuse and exploitation is often delayed in circumstances where there is domestic violence between adults, mental health or drug or alcohol misuse within the family.

7. Training should also be undertaken to raise awareness in identifying risk to a child whom the frontline practitioner may not have any direct contact. This can be in situations where they are working with a parent/carer or with a child who may have siblings and/or live with other children in the household.
8. Even in cases where risk has been properly identified, in our experience, professionals are often not aware of their legal obligations to protect a child and they do not know how to act on evidence where a child’s health or development is or may be impaired and/or where the child is suffering or at risk of suffering significant harm. This could be because: they do not have the benefit of working for an organisation that has a robust child protection policy or procedure; they do not have access to quality legal advice; or they do not have a nominated protection focal point.

Child trafficking and separated migrant children

9. In our experience, there is a lack of awareness among professionals of children in particularly vulnerable situations, such as trafficked children, or unaccompanied asylum-seeking children, which may result in lack of identification of signs of abuse and exploitation. Under the non-discrimination provisions of Article 2 of the UN Convention on the Rights of the Child, all children should have access to effective child protection mechanisms irrespective of their status or the arena of care where they find themselves. Unaccompanied migrant children are often highly vulnerable, at risk and in need of child protection measures. However, they often remain much more hidden to mainstream child welfare and protection services. The Laming Inquiry into the death of Victoria Climbie led to the Home Office’s UK Border Agency being made subject to statutory safeguarding duties consistent with s.11 Children Act 2004 safeguarding duties by virtue of s.55 of the Borders Citizenship and Immigration Act 2009 but of itself, this new duty has not made such children any safer.

10. The courts have consistently found that the UKBA have failed to comply with their safeguarding duties for unaccompanied migrant children and those in families, particularly when making decisions about the removal of children from the jurisdiction or when enforcing such actions against their families. These failures constitute a serious child protection risk and require consideration as to whether or not stronger statutory compliance measures and guidance is required to be put in place.

11. As set out in the submission of evidence by the Refugee Children’s Consortium, we recommend that the care of all separated migrant children and trafficked children come under the remit of the Children’s Minister in the Department for Education, rather than the UK Border Agency, which would help to ensure that priority is given to children’s safety and welfare over their immigration status. There is a conflict of interest in the UK Border Agency immigration officers (rather than child protection specialists) assessing whether an individual is a victim of trafficking as one of the two competent authorities for the National Referral Mechanism (NRM) while at the same time assessing credibility for immigration and asylum claims.

12. Better and more specialised training should urgently be put in place on child protection for all staff in the UK Border Agency and especially its enforcement, detention and escort contracting services and also in improving intra and inter agency cooperation on safeguarding within and between the UKBA and local authorities.

C. Factors affecting the quality of decision-making in referral and assessment, and variations across the country

13. CCLC considers that an important factor which affects the quality of decision-making in child protection referral and assessment is whether full consideration has been given to the child’s wishes and feelings. Article 12 of the United Nations Convention on the Rights of the Child sets out the children’s right to participate. It provides that governments must “assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child”, and must give “due weight” to these views “in accordance with the age and maturity of the child”. According to the UN Committee on the Rights of the Child, this requires governments to ensure, through legislation, regulations and policy directives that, the child’s views are solicited and considered in all care-related decisions, including whenever a decision is made to remove a child from his or her family. Governments must start with the presumption that all children are capable of forming and expressing views, and it must be up to authorities to disprove this presumption. Simply listening to the child is insufficient; the child’s views have to be seriously considered. Children’s participation rights are also set out in the domestic legislation, including in Section 1 of the Children Act 1989 and section 53 in the Children Act 2004.

14. The emphasis that the child’s voice should be heard and account taken of their wishes and feelings is emphasised in the Every Child Matters guidance, which states that “in the process of finding out what is happening to a child, it is important to listen and develop an understanding of their wishes and feelings”. The child’s wishes and feelings should be obtained within an appropriate timescale and in an appropriate manner to his or her age and understanding. It is not only vital for the practitioners to be aware of the child’s wishes and feelings to contribute to their decision-making in referral and assessment but for the child to feel that they are listened to and that their views are considered when decisions are being made about them.

65 UN Committee on the Rights of the Child, General Comment No. 12: The Right of the Child to be Heard, 20 July 2009, CRC/C/GC/12, para. 53.
66 UN Committee on the Rights of the Child, General Comment No. 12: The Right of the Child to be Heard, 20 July 2009, CRC/C/GC/12, para. 54.
67 UN Committee on the Rights of the Child, General Comment No. 12: The Right of the Child to be Heard, 20 July 2009, CRC/C/GC/12, para. 28.
68 Every Child Matters, p. 100.
15. CCLC have experience in representing children and we have had numerous cases where the child and young person have stated that they do not feel that their wishes and feelings have been properly ascertained and taken into account. An example of this is a recent case in which the CCLC represented “A”, a 15 year old girl who had experienced physical and verbal abuse at the hands of her parents. A was accommodated under s.20 of the Children Act 1989. A expressed great concern to her local authority that she would have to return home and about the risks that her parents posed to her siblings who remained in the family home. A also wished to have contact with her siblings. The local authority did not take any action regarding sibling contact or the concerns raised about the siblings despite A’s views. CCLC was instructed by A and private law proceedings were issued for A to have contact with her siblings. It was only as a result of CCLC’s involvement and making representations on A’s behalf that weight was placed on A’s views and concerns. The local authority acted and care proceedings were issued in relation to A’s siblings. Had A’s wishes and feelings been considered at an early stage, the delay that incurred by the local authority to act may have been avoided.

16. We therefore recommend that: social workers receive quality, in-depth and regular training on communicating with children and young people and on child participation, including techniques to communicate with, and ensure meaningful participation of very young children and children with disabilities and/or learning difficulties; Better supervision, performance management and assessment of social workers’ communication skills and participation work with children and young people; and Integrating the involvement of children in care assessments into the local authority performance framework.

D. Does the child protection policies and practices of non-social work agencies and government departments assist professionals to work together in the interests of the child?

17. CCLC is pleased that there appears to be developments by non-social work agencies to put child protection policies and practices in place to work together in the interests of the child. However although some employers, such as schools, colleges, health authorities and health trusts, are under a duty to have a child protection policy within their workplace placing a duty upon their employees to safeguard and promote the welfare of children, other professionals are not under an obligation to report to the relevant authorities where they suspect a child is at risk, although they would be highly criticised if they did not do so.

18. Having extensive experience in representing parents and children within pre-proceedings and acting for them in court proceedings, CCLC are aware of the importance of various agencies working together and imparting information to ensure that everyone works in the best interests of the child. Information-sharing is extremely important where a risk of abuse or neglect is suspected as a minor concern to one organisation as it might form part of a wider picture. It is imperative therefore that organisations have a clear child protection focused policy and practice to ensure that professionals can recognise potential risks to a child and know how to act.

19. Information-sharing is vital from the first suspicion that a child may be at risk prior to any court proceedings, and organisations should have clear policies and practices in place. Professionals need to be aware of the importance of keeping clear, accurate and legible records of any concerns that they have about a child and records should be kept up to date. Any policy should also reflect on how information should be stored in case of future use. CCLC have found that historic information can often provide vital insight into the family concerned. Any policy should also reflect the importance of considering all requests for disclosure of information for child protection purposes.

20. It is also vital that professionals are aware of how to co-operate and communicate effectively with other professionals and agencies. Professionals should be encouraged to participate in any multi-agency meetings in relation to a child such as the child protection conference, strategy meetings and case reviews. If direct participation is not possible, they should be encouraged to participate indirectly, for example, by telephone or by submitting a written report.

21. Non-social work agencies and government departments should also set out clearly the relevant training to be undertaken by professionals including on-going professional development training to help them safeguard and promote the welfare of children effectively.

November 2011

Written evidence submitted by the Social Care Institute for Excellence (SCIE)

A. EXECUTIVE SUMMARY

Good social work practice is the keystone for good child protection. Some of the characteristics of good practice are common to social work in all settings and levels. It includes strong analytical skills, the ability to engage with people using services and make effective relationships with them and the ability to use judgement based on available evidence about effective interventions, to this end, bureaucratic processes should follow from and support this kind of practice.
B. INTRODUCTION

1. The Social Care Institute for Excellence (SCIE) improves the lives of people who use care services by sharing knowledge about what works. We are an independent charity working with adults, families and children’s social care and social work services across the UK. We also work closely with related services such as health care and housing.

2. SCIE includes social work knowledge development as one of its key areas of activity. SCIE’s social work site includes products to support and develop critical thinking, analysis and the exercise of informed judgement. SCIE has developed the Professional Capabilities Framework, on behalf of the Social Work Reform Board. This provides an overarching framework for practice standards, with graded expectations at all career levels. These expectations incorporate recent Munro Review recommendations on child protection practice and emphasise sound analytical skills as a key component of practice.

3. SCIE has significant experience in identifying and disseminating best practice in child protection, including as part of a role as the lead for Safeguarding in the Centre for Excellence and Outcomes (C4EO).

4. SCIE has long-standing experience in promoting, identifying and disseminating best practice at the interfaces of adult and children social care and health services. That is, helping services to work effectively with families with multiple problems, rather than considering these as single issues in isolation. SCIE’s “Think Family” approach encompasses parental mental health and also services for disabled parents; parents with drugs and alcohol problems and the children of prisoners.

5. Since 2005, SCIE has been developing a systems approach to learning from multi-agency child protection practice, including untoward incidents. Our Learning Together model for case reviews has been used by more than twenty local authorities, and was cited in the Munro Review as leading developments in this area.

6. This work informs our submission to the Committee.

C. INFORMATION

Overarching points

7. We strongly support the analysis of the child protection system presented in the Munro Review and the development work of the Social Work Reform Board. We would particularly emphasise the following points from this analysis:

(I) Child protection is an inherently complex task that involves working with high levels of uncertainty. Statements about what constitutes good practice should set a framework for the exercise of professional judgement in a particular circumstance.

(II) Fear of blame can lead to an over-reliance on compliance with policies and procedures, at the expense of the exercise of professional judgement.

(III) Even well-designed top-down reforms can have adverse consequences. The child protection system therefore needs to be equipped to engage in continuous learning and adjustment.

(IV) Child protection, and other social work settings, require a workforce at practice and management levels, that is well educated and able to develop high levels of skill throughout the social work career, as set out in the SWRB’s Professional Capabilities Framework

8. We question how “the child protection system” is defined? At present, this term may be commonly used to denote statutory child protection services and procedures. However, many services, including universal services, should have a role in protecting children.

Does the child protection system allow for effective identification of, and early help to, children at risk of different forms of abuse and exploitation?
(Including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

9. The case reviews we have conducted to date suggest that the child protection system is currently less well equipped to accommodate neglect compared to physical abuse and other incidents. In contrast to other types of abuse, neglect is frequently chronic and “low-level”. If child protection “gatekeeping” teams (eg Duty and Assessment Teams) make their decision about whether to accept referrals based on current levels of risk, they may be less likely to accept neglect cases. However, this does not acknowledge the cumulative impact of neglect on children and young people.

10. This is also linked to the issue of “requisite variety” in children’s services. Children’s social care services are focused on providing short term interventions, after which families are “discharged”. Most services are not set up in such a way that enables them to provide immediate, periodic or long-term support needed by many families in which chronic neglect occurs. Where assessment is understood as a temporal and procedural stage, an unintended consequence can be that help is withheld until the family has been “assessed”. These are among the key research messages in C4EO’s Safeguarding Briefing 1 on effective interventions.
Factors affecting the quality of decision-making in referral and assessment, and variations across the country

11. Workload is a key factor affecting the quality of decision-making in referral and assessment. As highlighted in the Munro Review, there has been an increase in the number of referrals to children's social care in recent years. The extremely high levels of referrals make it difficult for workers to thoroughly consider each referral.

12. Recent academic research in five “duty and assessment” children’s social care teams (Broadhurst et al. 2010) vividly describes the unintended consequences of combining a high workload with immovable deadlines. This includes referrals being (unnecessarily) returned to the referrer for more information and routinely recommending “no further action” for referrals for older children, on the basis that they have lived longer with the problems and are more resilient. As the authors point out, these findings are not intended to criticise individual workers, but show how the underlying conditions in the services can lead to sub-optimal practice.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

13. Our practice development experience suggests that careful collaborative work between children’s services in a locality help to prove and agree thresholds that support effective intervention. The same problems of different threshold in different agencies and localities becomes harder to manage where agencies are not co-terminate eg an NHS acute trust may be working with several LAs, including those covered by its regional services.

14. Thresholds for intervention, removing children from their families and returning them home from public care are examples of the complexity of decision making requiring careful judgement, and the need for a variety of patterns of support. Wade et al (2010) describe these judgements as based on clear evidence of sustained change in parenting capacity, and provision of support services to assist parents and children. Farmer et al (2011) highlights the need for high levels of support, often over time, when children are returned home.

15. The importance of skilled social work judgement, and its relationship to procedures and service targets, is echoed in SCIE’s recent report on adult safeguarding, an area of practice that echoes many of the issues for child protection services:

“Social work has been deskilled by 20 years of care management and ... some of this, the risk assessment, the risk management, we’re in a place where we now have to almost retrain some of our staff to do this, and that underlying this the challenge is not about, do you have the right tools, it’s actually do people have the confidence and the competence to do the job which is about safeguarding vulnerable people. It’s really as simple and crude as that.”

16. Our case review work suggests that current government policy may have created some unintended consequences. One is a tendency to apply lower levels of scrutiny and assessment to placements with family members, for example grandparents, compared to foster carers. This is concerning given what is known about intergenerational poor parenting and abuse.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

17. Our work suggests that there is still some way to go in terms of truly joined up working between the various agencies involved in child protection.

18. Information sharing is a key barrier to working together, particularly for cases in which it is not yet clear whether a child is at “significant risk of harm”. Once significant harm is anticipated, information sharing can proceed. In the absence of this, parental consent must be obtained, and many agencies and professionals are reluctant to seek this.

19. Inter-agency, as well as inter-professional working is skilled work at various levels of the organisation. SCIE has produced an elearning resource to support this and the theme runs throughout SCIE’s Think Family products.

D. RECOMMENDATIONS FOR ACTION

Overarching

20. Threshold setting and the timing and duration of interventions should be informed by professional judgement and the evidence about effective interventions and bureaucratic processes should then follow from, rather than determine practice decisions.

21. As highlighted in the Munro Review, it is important to build capacity within the multi-agency child protection sector for ongoing learning and improvement. SCIE’s Learning Together is a “systems” model of organisational learning that can be used across agencies involved in safeguarding and child protection work. The Department for Education is funding SCIE’s capacity building for this work.
22. Case reviews and Serious Case Reviews are an important source of this learning. The Munro Review describes the SCIE Learning Together model as providing a workable model to be used as an illustration for future development. We support the Munro Review recommendation that a systems approach be taken to Serious Case Reviews, and are working with Government to progress this recommendation.

Effective identification

23. There is a need for guidance on how to account for the cumulative impact of long term abuse and neglect when assessing children and families, and determining access to services.

24. It would also be helpful to introduce a common terminology and grading for neglect, eg the Graded Care Profile which is currently being evaluated.

Referral and assessment

25. Take action to reduce the volume of referrals being received by duty and assessment teams. This is a difficult task, but the following may help:
   (i) Increased understanding amongst other agencies about what the role of children’s social care is (and what it is not), to reduce the numbers of inappropriate referrals made to CSC.
   (ii) Acknowledge that duty and intake work is among the most complex and skilled areas of social work practice and that this should be staffed by skilled and experienced social workers and managers.
   (iii) Increase understanding in local areas of the Common Assessment Framework—this is a key route for obtaining support for families who do not meet child protection thresholds.

Inter-agency working

26. Government should investigate effective procedures and IT arrangements for information sharing and support local areas to implement these. Family Intervention Projects achieved this through the use of dedicated officers authorised to share information with other services. In London Borough of Islington, all families are asked to give permission for all their details to be shared between agencies.

REFERENCES


November 2011

Written evidence submitted by the Iranian and Kurdish Women’s Rights Organisation (IKWRO)

SUMMARY OF KEY POINTS

1. In order to ensure that education professionals are able to identify cases of female genital mutilation, forced marriage and “honour” based violence early on, the government must improve their understanding of these issues and their awareness of the warning signs.

2. There is an urgent need to improve collection and dissemination of data on prevalence of female genital mutilation, forced marriage and “honour” based violence in different parts of the country, and to use this data to ensure that local areas with high prevalence are adequately addressing the problem.

ABOUT THE AUTHOR

3. IKWRO is a registered charity (number 1104550) which provides advice and support to women and girls from the UK’s Middle Eastern communities who are facing forced marriage, honour based violence, female genital mutilation, domestic violence or other forms of abuse.

4. As well as assisting individual women and girls, we provide advice and training for professionals from education and other sectors to build their understanding of issues such as forced marriage and female genital mutilation and to improve their ability to assist women and girls at risk. We also campaign and advocate for better laws and policies to protect the rights of women and girls from ethnic minorities.
5. We will limit our comments on the child protection system to children who are at risk of female genital mutilation (herein FGM), forced marriage and “honour” based violence (herein HBV), since this is our area of expertise.

On whether the child protection system allows for effective identification of, and early help to, children at risk of FGM, forced marriage and HBV

FGM

6. Awareness of what FGM is and who is at risk is still too low among education professionals in the UK. IKWRO regularly provides training to professionals from the education sector on issues including HBV, forced marriage and FGM, and it is our sense that many still do not understand the level of physical and psychological pain that is inflicted on children who are subjected to FGM. Most professionals we speak to also have no awareness of the warning signs that a child may be at risk of FGM, which include the child:

- Being from an FGM practising community, particularly if the family is not well integrated into UK society.
- Being withdrawn from Personal, Social and Health Education by her parents.
- Having older siblings or a mother who have undergone FGM.
- Preparing to return to her home country.
- Saying that a special ceremony or party is going to be held in her honour, or that she is going to undergo a special procedure.
- Talking about a special visitor who is coming from overseas.

7. It is also important that education professionals are able to identify cases where a child has already been subjected to FGM, and understand their role in ensuring that appropriate aftercare can be provided to the child. Because FGM is illegal in the UK, parents will not take their children to a doctor when they are suffering the side effects of the procedure. If a child from an FGM practising community is absent from school for prolonged or repeated periods or returns from a trip overseas withdrawn and upset, and particularly if a child seems to be in physical discomfort, is spending a lot of time in the bathroom or is suffering from constant menstrual or urinary problems, then education professionals, who spend a significant amount of time with children, need to know what they should do. Their intervention can play a vital role in ensuring that the child receives the aftercare they need, that younger siblings are protected and that where appropriate a criminal investigation can be initiated.

8. In February the FGM Coordinator at the Foreign and Commonwealth Office released multi-agency practice guidelines which are designed to help professionals from a range of sectors to more easily identify children at risk of FGM and to more rapidly provide help to such children. However IKWRO and many other organisations working on FGM are very concerned that the guidelines have not been widely circulated and are not reaching frontline staff in schools. The guidelines were sent by email to senior officials in local authorities, organisations working on FGM are very concerned that the guidelines have not been widely circulated and are not reaching frontline staff in schools. The guidelines were sent by email to senior officials in local authorities, but the decision about whether and how to roll them out has been left to local directors. Unlike the Forced Marriage Guidance, these guidelines are not on a statutory footing and there is no obligation on local authorities to implement them.

9. The post of cross government FGM Coordinator was axed as of 1 April 2011, leaving a significant leadership gap. There is a person within the Interpersonal Violence Team at the Home Office, but they are working on other issues alongside FGM. In any case, what they are able to achieve is very limited by the fact that they have little budget for rolling out the FGM guidelines more proactively. They are available on the Department for Education website (and apparently on other websites aimed at teachers, although we could not find these through google search) but these will only be accessed by the most pro-active professionals. Much wider efforts are needed to ensure that all frontline education professionals have the information they need to be able to spot children at risk and protect them.

Forced marriage

10. Forced marriage is not a crime in the UK, although it is recognised as a civil wrong under the Forced Marriage Civil Protection Act 2008. A young person who is at risk of forced marriage or who has already been subjected to it can apply to the courts for a protection order, which bans their family, their spouse and others from taking certain actions—eg going within a certain radius of their home or school, contacting them by telephone, taking them out of the country and of course contracting them into marriage.

11. The young person can apply for a protection order themselves, or this can be done on their behalf by the police, the local authority and other agencies. In order for this to happen it is vital that they have access to information about their rights under the law, and that they receive the necessary support from professionals such as teachers, school counsellors and the social services.

12. In 2008 the government produced statutory guidance on forced marriage setting out that all Chief Executives, directors and senior managers have an obligation to ensure that their staff are aware of their...
responsibilities and obligations when they come across forced marriage cases. The guidelines are based on the “one chance” rule, that is their staff may only have one chance to speak to a potential victim and if the victim is allowed to walk out of the door without support, that one chance might be wasted.

13. The forced marriage guidance is now three years old, yet in many schools there is still a total lack of understanding of the issue. Through our outreach work with schools and colleges, as well as through the training we provide, IKWRO regularly encounters education professionals who simply do not understand how serious forced marriage is, who have no idea of how to spot the warning signs and who do not realise that they have obligations to protect young people at risk. We can only assume that if the school staff are not aware of the issues, then most likely the students do not have access to any information about their rights, in the form of posters, leaflets or class discussions.

14. Worryingly, what we have also found is that in schools based in communities where forced marriage is very common, the teachers and other school staff know that it is happening but treat it as a cultural practice, and many still lack understanding of the difference between arranged and forced marriage. FM can mean abduction to another country, emotional, psychological and physical pressure to get married, often to someone much older than them. Once married the girl will be repeatedly raped, may be subjected to domestic violence, may be forced to get pregnant and may be kept abroad for a long time, cut off from any assistance. When she returns to the UK she will usually be forced to sponsor a visa for her husband. Education professionals who think that forced marriage is a cultural practice simply have no real idea of what happens to the young women who are subjected to it.

15. We recently attended a safety fair at a London sixth form college with a large number of students from Middle Eastern backgrounds. These communities are growing quickly in the UK at the present time, and many of the girls we spoke to were recently arrived from countries including Iraq, Afghanistan, Lebanon and Morocco and had no idea of their rights under UK law. We also spoke to the student counsellor about the issue of forced marriage. She said that she had had many students who were being forced to marry against their will. When asked what assistance she provided, she said that she would “just offer a shoulder to cry on”. She was sympathetic to students, but she seemed to take the practice of forced marriage for granted. She had no concept of the fact that this is a violation of human rights, and that she should contact the police, the Forced Marriage Unit or a specialist organisation like IKWRO if she had any concerns about the student.

16. Our Outreach Officer has since returned to that particular college to provide training on forced marriage to the student counsellor and other staff. However, NGOs like IKWRO cannot reach everyone. Many organisations are facing funding crises at the moment and have to focus their operations on frontline work with victims only. It is the government’s responsibility to ensure that their guidance has been rolled out in schools, and the Department for Education need to take the lead on this. We are very concerned that when the student counsellor—the person specifically charged with students’ welfare—in an inner city college with a large number of at-risk young people does not understand the issue of forced marriage, this is reflective of the bigger picture.

17. At the end of last year the government undertook a review of the implementation of the forced marriage guidance. Almost a year later the results of the review have not been made public. During that time the Home Affairs Select Committee has published a report on forced marriage, in which they have also highlighted the failure by some schools to adequately protect young people at risk. The Committee’s report emphasised the need for the Department for Education to “provide more active support to teachers to enable them to carry out a role which may risk upsetting cultural sensibilities but is nonetheless vital for child protection”. It also recommend that “Ofsted inspectors pay particular attention to policies in place to deal with forced marriage in their assessments of the safeguarding arrangements of schools where pupils are likely to be at risk of forced marriage”.

Honour based violence

18. We find that awareness of HBV is even lower than that of forced marriage. This is partly due to a lack of leadership on this issue at government level. While the Association of Chief Police Officers is supposed to champion this issue, they have not convened a national meeting on HBV for over two years, and have never reported on progress in relation to their 2008 HBV strategy. There is an assumption that the Forced Marriage Unit are taking care of HBV but their remit is in fact very clearly limited to forced marriage, and as a result there is a real policy gap in this area.

19. At the level of schools, this can often mean total ignorance of the problem. For example we recently handled a case involving a 15 year old girl who was suffering severe HBV from the age of 12, when her father learnt that she was mixing with boys at school. The girl was from a part of London where the Kurdish community is highly concentrated, and where school staff really should be aware of the issue of HBV. On one occasion the girl was kept back from school for a meeting, and she was so afraid that her father would be angry that she begged the teachers to ring home and explain why she would be coming home late. This should have alerted the school to the fact that something was wrong, but they simply put it down to the father being strict. The girl had also had prolonged absences from school after she had been beaten by her father (one
instances with a metal pole and in one case a saw) and when he had burnt her hands on the stove. Again the school did not pick up the warning signs or offer any protection to the girl.

Factors affecting the quality of decision-making in referral and assessment, and variations across the country

20. One of the issues which we often come up against is the question of whether local authorities, and indeed school boards, give priority to issues such as FGM, forced marriage and HBV. In the London borough of Islington for example the response to forced marriage and HBV has been very robust, because the local head of children’s services Sarah Pepper has been very committed to tackling these issues. Sarah has encouraged her staff to undertake training and to build their understanding (in line with their responsibilities under the Forced Marriage Statutory Guidance) and has built strong links with expert NGOs through the Islington Harmful Traditional Practices Forum.

21. As discussed above, there have been challenges in ensuring that local authorities implement the Forced Marriage Guidance, and we are currently awaiting the report from the government’s review of the Forced Marriage Guidance. With FGM, the situation is even more difficult as the FGM multi agency practice guidelines are not on a statutory footing, and it is entirely up to local authorities to decide what to do with them. In some areas for example Bristol where there is already strong commitment to tackling FGM, the guidelines are probably seen as a useful resource and are likely to be rolled out. However in other areas, including many with large FGM practising communities, we are concerned that this is not happening. The London borough of Lambeth for example has a large number of immigrants, including many from FGM practising communities. However when IKWRO attended a conference to input into Lambeth’s Violence Against Women and Girls Strategy last March we found that the strategy contained very limited commitments on FGM, and made no mention of the FGM guidelines which had been released a month previously. When we asked about this we were told that FGM was not a priority in Lambeth. IKWRO followed this up after the conference, and ensured that commitments to roll out the FGM guidelines were included in Lambeth’s final strategy, but we were not able to do the same with every local authority in the country.

22. Part of the problem is that there is no proper data on the prevalence of FGM in different parts of the UK so staff in local authorities or schools may believe that FGM is not a priority in their area, when in fact there may be many girls and young women at risk. With forced marriage and HBV many local police forces are now noting incidents in their recording systems, although this data is not published anywhere and it is unclear whether it is used. It is vital that the government finds ways to improve the national data picture in relation to prevalence of issues such as FGM, forced marriage and HBV, in order to ensure that these practices are given the priority they deserve in local areas where they are taking place.

23. We have also found that there is a lack of understanding of which communities practice FGM. While many practitioners associate FGM with Muslim communities from countries in the horn of Africa such as Somalia, Sudan and Egypt, FGM is practiced in Muslim and Christian countries all across the continent of Africa, and in a number of Middle Eastern and Asian countries. In Iraqi Kurdistan for example it affects 80% of women in some areas, yet prevention initiatives rarely focus on this community. It is vital that professionals have a broader understanding of which communities are practising FGM, particularly in areas where practising communities are concentrated.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

24. In situations where it is feared that a child is at risk of FGM, education professionals have a duty to inform social care or the police, in line with Section 47 of the Children Act 1989. It is vital that education professionals, who are not after all experts in FGM, have the confidence to make this referral. It is then up to those sectors which are experts in safeguarding children to decide what action should be taken. Teachers and other education professionals should be clear about their duties to report, and should not be afraid of getting it wrong or offending the parents or community.

25. Many parents carry out FGM because of pressure from the wider family or community, or because they genuinely believe that they are doing what is best for their child, and they may otherwise be attentive and loving parents. In such cases there are mechanisms through which children can be protected from FGM while still remaining within the family home, for example through Prohibited Steps Orders. When both parents are engaged in an open discussion of the health risks and side effects of the practice, and when they realise that they are under threat of law, they can often be persuaded not to carry the procedure out. Children at risk of FGM should only be removed from their parents when there are clear indicators that the parents will disobey any order, and when all alternatives have been exhausted.

26. With forced marriage and HBV the situation is different, in that once the family has decided that their daughter must marry (or that she has damaged the family honour and should be punished) it is often very difficult to persuade them otherwise. Teachers and other education professionals need to be very clear that they must never contact or mediate with the family if they suspect that a young person is at risk of forced marriage or honour based violence. This will only alert the family that the authorities are aware of what they are doing, and can put the young person at further risk.
Written evidence submitted by Centre for Child and Family Research, Equality Now

1. The term “female genital mutilation” (FGM) also called “female genital cutting” and “female genital mutilation/cutting”) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. These procedures are classified into four types: clitoridectomy or the partial or total removal of the clitoris/prepuce (Type I), excision, the partial or total removal of the clitoris and labia minora, with or without excision of labia majora (Type II), infibulation, the narrowing of the vaginal opening through the creation of a covering seal (Type III) and finally, other types that include pricking, piercing, or other harmful procedures to the genitalia for non-medical reasons. (Type IV). Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and three million girls are estimated to be at risk of undergoing the procedures every year.

2. There is recognition that FGM is practised in some minority communities in the UK. Statistical data on FGM prevalence in England and Wales suggest that nearly 66,000 women with FGM were living in England and Wales in 2001, while 24,012 of girls under 15 were at high risk or may have already undergone FGM. These numbers are likely to have increased since then as reflected in the increase in the estimated percentages of all maternities which were to mothers with FGM, for example, the estimated numbers of births to women of all maternities which were to mothers with FGM, for example, the estimated numbers of births to women with female genital mutilation living in London have risen from 4,238 women giving birth in 2000 to around 7,000 in each of the years 2007 to 2009.

3. The most common objective of FGM is the control of a woman’s sexuality. Due to the paucity of research on FGM in England, it is not clear about the attitudes, perceptions and motivations of women and families from FGM practicing countries, including those who have stopped practicing it and are opposed to it. A 2011 study, showed that Somali and Sudanese study participants from the UK and the Netherlands recognised several positive aspects of FGM, such as being considered a “good” Muslim woman, the increasing of her status and that of the family, and the higher chances for marriage.

4. FGM has serious health, sexual and psychological consequences during a woman’s lifetime. There are currently fifteen specialist NHS clinics in England offering specialist services to address reproductive health and the narrowing of the vaginal opening through the creation of a covering seal (Type IV). Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and three million girls are estimated to be at risk of undergoing the procedures every year.

5. Other reasons may also include the belief that it increases a man’s sexual pleasure or that men desire “circumcised” women. Furthermore, FGM may also serve as an affirmation of immigrants’ cultural identity.

6. FGM prevalence in England and Wales suggest that nearly 66,000 women with FGM were living in England and Wales in 2001, while 24,012 of girls under 15 were at high risk or may have already undergone FGM. These numbers are likely to have increased since then as reflected in the increase in the estimated percentages of all maternities which were to mothers with FGM, for example, the estimated numbers of births to women with female genital mutilation living in London have risen from 4,238 women giving birth in 2000 to around 7,000 in each of the years 2007 to 2009.

7. Although female genital mutilation is most prevalent in 28 countries: the western, eastern, and north-eastern regions of Africa, some countries in Asia and the Middle East (including Iraq Kurdistan), due to migration FGM is also found amongst some immigrant population groups in the UK.

8. One of the challenges with current government policy is that it leaves children who are not permanent residents or British nationals without protection. The government must urgently revisit the position of non-resident children in relation to FGM and other safeguarding issues.

9. An additional challenge is the wider context of funding cuts in the UK. As discussed above the government has not provided sufficient funds for dissemination of the FGM multi agency guidelines and the cross government FGM Coordinator post has been axed, both of which have meant that professionals are not getting the information they need.

10. We also have concerns in relation to delays in releasing the government’s review of implementation of the Forced Marriage Guidance. We suspect that these delays are taking place because the review will probably highlight high level failings in implementation at a time when there is no money to tackle these.

11. We are also concerned by threats to policing budgets and to the National Policing Improvement Agency, which is tasked with rolling out training to the police. The NPIA consulted IKWRO and other expert organisations on a new training module on FGM, forced marriage and HBV a year ago but the training has never materialised, while awareness of these issues among many frontline officers is much too low. At present it is not clear whether the NPIA will even continue to exist. Moreover in the context of wider cuts to policing (where the government have pledged that they will not cut officers on the streets) we are concerned that there will not be enough qualified people to do the complex investigative and safeguarding work which is necessary to protect children from these forms of violence.

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complications for clients with FGM. Immediate complications of FGM can include severe pain, shock, haemorrhage (bleeding) and bacterial infections, which may lead to death. In the long-term, FGM is associated with severe health risks, such as recurrent bladder and urinary tract infections, cysts, infertility, childbirth complications or newborn deaths. Key times of FGM-related anxiety in a woman’s lifetime were identified as: menstruation, pre-marriage (anticipation of wedding night and ensuing physical pain), following marriage (fear of intimacy and pain related to sexual intercourse), pregnancy and childbirth. Psychological consequences include post traumatic stress disorder and anxiety, while other important consequences relate to reproductive health problems. On the other hand, immigrant young women in cultures with different norms and attitudes may face other psychological challenges. A study on FGM consequences in the Netherlands found that almost one sixth of the women met the criteria for post traumatic stress disorder and around a third were found to suffer from anxiety and depression. Furthermore, FGM had a considerable impact on family life, with the relationship with their partners being essential to their sexual well-being. Some women were troubled by the fact their mother allowed their mutilation to take place, others were angry with men, who were perceived as the ones benefiting from FGM. Also, feelings of inferiority to non-circumcised women, shame, and even exclusion were reported. Moreover, many respondents found it difficult to talk about FGM, which was considered a taboo.

5. Female genital mutilation of any type has been recognised as a harmful practice and a violation of the human rights of girls and women in a number of international and regional human rights treaties and consensus documents, of which the UK is a signatory party. In communities where FGM is a traditional practice, it is mostly carried out on minors at some time between infancy and the age of 18 which makes it a major human rights issue for girls. Trends in the practice in Africa indicate that there is a lowering of age of mutilation by parents as informed older girls are likely to resist FGM. A 2011 London study on harmful practices also suggests that in the UK, FGM is more likely to be performed on girls less than 10 years old than on girls above this age. The Convention on the Rights of the Child which the UK is signatory to states that any person below the age of 18 has the right to protection from activities or events that may cause them harm and that they need special safeguards and care, including appropriate legal protection.

6. In the UK there have been a number of legal and policy developments, primarily criminal legislation on FGM enacted in 2003, which restated and amended the Prohibition of Female Circumcision Act 1985. An extra territoriality clause was brought in to close a loop hole in the 1985 Act that made it possible for parents to take girls outside of the UK to undergo FGM without prosecution. On paper FGM is considered a form of child abuse and violence against women and girls. Since the early 1990s, there has been numerous guidance on FGM produced by health professional bodies (RCN, RCM, BMA, and RCOG), safeguarding boards and local authorities aimed at providing some direction on what professionals should do on FGM. In 2001, the government published multi-agency practice guidelines on FGM to raise the awareness of professionals on FGM. In September 2011, the CPS also published guidelines on prosecuting FGM. Despite FGM having been the focus of three decades of educational campaigns by civil society groups in the communities concerned, numerous guidelines produced on FGM as well as training on FGM provided for professionals, FGM persists and there is indication that it is growing. There is no national action plan on FGM.

7. FGM is performed largely on girls under the age of 10 who do not have a voice to report or to seek help. It is a hidden practice as it is condoned by the family and minority community members who practise it. Although attitudes towards FGM are gradually changing in the communities concerned, this does not necessarily correlate to behaviour change on FGM because in practising communities, the family unit is wider than the nuclear family unit. The decision making on FGM involves wider members of the extended family. Younger adults who may be against FGM are less likely to report to the authorities as they fear recriminations including ostracism from extended family and community members.

8. The child protection system’s response to FGM is reactive. It responds mainly to emergency crises cases that come to its notice. There is no systematic joined up work on FGM. There has been a lack of early identification and early prevention work in relation to FGM. The attitude of policy makers is to ghettoise the problem and place the responsibility of stopping FGM solely on black women from the communities directly concerned. However, it is important to note that whilst community awareness raising and behaviour change activities organised by black women are very important in (a) challenging in the value system (eg social control of females in these communities), (b) providing safe spaces for young women experiencing health problems as a result of FGM, there are limitations to community efforts to prevent FGM.

84 HM Governmnt .Multi-Agency Practice Guidelines:Female Genital Mutilation, 2011
Due to immigration policy of dispersal, girls and women affected by FGM are spread out all over the country and the reach of civil society organisations to families are limited to inner cities and in areas where there are large sectors of specific populations;

Girls—being minors—who are affected by FGM are less likely to disclose or seek help and it is vital for statutory agencies to intervene;

FGM is a gender power issue. It cannot be stopped merely from community awareness raising just as forced marriages cannot be stopped through community awareness.

Locally, policies and mechanisms already exist to support joined up work on vulnerable children and families, such as the Common Assessment Framework (CAF), yet, FGM is not fully embedded within these processes. This effectively means that professionals are not utilising existing powers in cases where there are clear child protection and safeguarding concerns. Whilst at policy level, FGM is acknowledged as a child protection issue for largely African girls, it is not addressed on an equal footing as other forms of child abuse. The seriousness of the abuse is lessened by many professionals accepting the notion that parents who commit the abuse of FGM “love their children”.

Bearing in mind that the majority of girls at high risk of FGM are minors under the age of 10, promoting information including the law to parents and monitoring the wellbeing of minors through the health and social care system for the under-fives and work in primary schools are very important but this is currently ignored or inappropriately targeted. For example, the Metropolitan Police work on FGM focuses on girls in secondary schools but it is known that most of the FGM procedures occur during the primary school stage. Moreover these young girls are quite powerless to stop FGM at the family level. The Home Office has also informed the British Missions abroad to afford protection for British citizens who are taken abroad for FGM but the girls are too young to access this support.

The government plans to integrate harmful practices education for young people into Personal, Social and Health Education (PSHE). However, PSHE is not compulsory as parents are allowed to withdraw the children from PSHE particularly sex education. It should be noted that girls from Black Minority and Refugee communities are likely to be withdrawn from such classes for cultural and religious reasons. Moreover more schools are being encouraged to be independent and are likely to favour non introduction of PSHE.

Since the majority of the primary victims of female genital mutilation are minors under the age of 10, detection is more difficult as girls are too young to resist, seek help or report the crime. Therefore greater and consistent levels of monitoring are required to protect girls from undergoing genital mutilation. An improved response would require that female genital mutilation is fully integrated into the safeguarding children framework and that it is given equal weight and attention as with other forms of child abuse.

Currently, the safeguarding framework practice is not consistently applied to female genital mutilation, although on paper FGM is recognised as form of abuse. The Common Assessment Framework (CAF), a holistic needs assessment tool, already recommended for use in Working Together to Safeguard Children, is the central mechanism for assessing needs and risks and information-sharing between various agencies (HM Government 2010b). It should be systematically applied for the early identification of needs and provision to meet the needs of girls who are vulnerable to female genital mutilation. A key component of CAF is the appointment of a lead professional, who acts as a single point of contact.

The systematic application of CAF will address the needs of minors vulnerable to female genital mutilation and will be more aligned to the French approach of monitoring the under six year olds but without the need for the intrusiveness of mandatory inspections of girls’ genitalia. If a midwife helps with the birthing process of a mother who has undergone female genital mutilation and whose baby is a girl, for example, she should use CAF, be able to flag up the potential future risk to the girl. This information should be shared with the under-fives health visitor who is in a unique position to be alert to the risk of female genital mutilation during on-going engagement with the family through the baby and child health clinics for the following five years. Since all families with children in the UK are registered with a GP practice, this should provide another avenue to flag up potential risk to girls from practising communities for the attention of the appropriate safeguarding leads in child health clinics and schools.

In this context, all new refugees and asylum-seekers registering with GP surgeries from practising countries with girls should be asked whether the girls have undergone female genital mutilation and this should be followed up by the appropriate professional. Safeguarding leads in schools should also be alert to the fact that girls are most vulnerable to the risk of female genital mutilation during the primary school stage.

Better monitoring of girls through primary would enhance joint working between professionals leading on child protection, safeguarding in GP practices, schools, social services departments and the police.

Once the mechanisms for effective levels of multi-agency working are in place, professionals would then be required to abide by the rules of mandatory reporting to social services or to the police, similar to the duties that exist in reporting cases of child abuse. This should help to improve levels of third party reporting and detection.

The Common Assessment Framework provides a standardised shared approach to carrying out assessment of a child’s additional needs and deciding how those needs should be met. The CAF aims to help the early identification of such needs and promote a coordinated service provision to meet them.
18. An example of promising practice which highlights an integrated approach is Bristol Council, which has initiated a targeted approach on FGM in relation to minors. 1,500 front-line professionals working in health, education, the police, social services and the voluntary sector have been trained to recognise the signs in girls who might be vulnerable to FGM. There is a strong partnership approach and Bristol Council has established a strong multi-agency approach with a Public Safety Board, represented by VAWG local authority leads, NHS leads, child protection teams, the police, local and national women’s organisations with a specialism on FGM. The group is currently developing an area-wide FGM strategy to improve multi-agency responses, levels to the issues. If such an approach were to be applied across all authorities, FGM would be embedded within the safeguarding children framework, there is a stronger likelihood that greater progress will be made to eliminate FGM much sooner.

November 2011

Written evidence submitted by Local Government Group

1. Introduction

The Local Government Group is here to support, promote and improve local government.

Local government is facing the most radical changes, as well as the most significant opportunities, in a decade.

We will fight local government’s corner and support councils through challenging times by focusing on our top two priorities:

— representing and advocating for local government and making the case for greater devolution; and
— helping councils tackle their challenges and take advantage of new opportunities to deliver better value for money services.

The LG Group covers every part of England and Wales, and works with the individual political parties through the political group offices.

LG Group welcomes the opportunity to provide views on the child protection system. This document has been agreed by the LG Group’s Children and Young People Programme Board.

2. Summary

Responses are given below to the specific areas of inquiry outlined by the Committee. The four areas are closely interlinked and two key issues recur across them: the difficulties associated with managing the inherent uncertainty and risk in child protection and the importance of effective multi-agency working.

In addition, there are two subjects which do not fall into any of the specific lines of inquiry but that the LG Group feels would be relevant to refer to.

Munro Review

The Munro Review provides a thorough and well-considered analysis of the child protection system that has been largely welcomed by those working in it. Local government had close involvement in the Review and the LG Group has welcomed it; in particular the emphasis on freeing up professionals to use their judgement in the best interests of the child. We are now working with councils, government departments and other partners on its implementation. The Review contains much detail and richness of content that is relevant to the Committee’s inquiry and the implementation of the recommendations will have an impact on the way the child protection system operates. This does represent a significant systemic change and as such, will take some time to realise.

Sector-led improvement

Protecting vulnerable children is one of the most important things that councils do and there is no room for complacency when it comes to performance of these services. The LG Group has developed an approach to self-regulation in the sector that will help councils strengthen their accountability and revolutionise the way they evaluate and improve services. This is based on the principles that councils are responsible for their own performance; stronger local accountability drives improvement; and councils have a collective responsibility for performance in the sector as a whole. The support outlined in Taking the Lead represents a core part of the LG Group’s “offer” to the sector.

In this context, a new system for sector-led improvement of children’s services is currently being developed. The Children’s Improvement Board (CIB), which comprises the Local Government Group, the Association of Directors of Children’s Services, SOLACE and the Department for Education is a direction setting and decision-making group that is responsible for the overall delivery of the programme. The core of this model is

86 http://www.local.gov.uk/taking-the-lead
based on councils open up their self assessment and improvement planning activities in children and young people’s services to a process of rigorous peer challenge.

The CIB is supporting councils to develop a detailed understanding of their performance and to develop the ways in which the system is held to account, serving both as an early warning mechanism for deteriorating performance and a guide to areas that can be prioritised for improvement. This will result in priorities that reflect the needs of local communities rather than meeting centrally driven performance indicators, with a hard edge of accountability in the relationship between council leaders, lead members, chief executives, and directors.

3. Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation

As described by Professor Munro in her Review, the identification of children at risk of abuse can be difficult. Abuse and neglect often occur in the family home; adults can go to significant lengths to conceal problems; and the evidence of abuse and neglect is not always clear.

The Munro Review also highlights that due to (well-intentioned) past reforms that have attempted to manage risk, social workers have been constrained by an emphasis on compliance with rules and form filling, which has meant less time spent with children and their families. The recommendations to reduce bureaucracy and place more value on professional judgement is very welcome in order to free up social workers. The more time social workers are able to spend with children and families, the better picture they are likely to have of what is happening in those families and therefore the level of risk and appropriate support.

The child protection system is comprised of many different organisations and actors. Many services other than children’s social care have a key role to play, particularly when it comes to the identification of children at risk. Health visitors, GPs, schools, health and police, amongst others, all have interactions with children and families and effective communication of concerns about children’s well-being has rightly been recognised as crucial.

As noted above, the health service has a key role to play in identifying children at risk and providing early help. Ensuring that the reforms of the health system fully take into account safeguarding children is therefore of vital importance. The Departments of Health and Education are developing a joint work programme to address some of the issues raised by the reforms, to which the LG Group, alongside other organisations, is contributing to. Issues to be addressed include for example, whether GPs have sufficient knowledge and understanding of safeguarding responsibilities, particularly in light of their new commissioning role and the relationship between Health and Wellbeing Boards and Local Safeguarding Children Boards. The level of vacancies of designated professionals within the health service has also been raised by councils as a cause for concern.

We still have concerns regarding the division of responsibility for children’s public health between local authorities (5–18) and the NHS Commissioning Board (0–5). Although the Government has given a commitment to transferring full responsibility for children’s public health to local authorities by 2015, local authorities should have this responsibility from the outset as they are better placed to deliver a preventative approach through whole-family and parenting support interventions, and are better able to address child poverty, inequality and poor health and social outcomes.

Several reviews, including those carried out by Professor Munro and Graham Allen MP, have highlighted the benefits of a shift from reactive services to early intervention—both in terms of early years and early in the development of problems. There are both financial and moral arguments for early help, but significant challenges remain to its implementation and there is no silver bullet solution. One issue is how to fund early help when councils must also in parallel fund statutory work and LG Group is interested to explore how innovative financing through the proposed Early Intervention Foundation could help address barriers. There also remains a significant question about the role of health service and schools in providing early help.

The Early Intervention Grant presents opportunities for councils to pool resources and combine local efforts to further help young people at risk and their families. However, there are many groups that the Early Intervention Grant aims to assist and the circa £2 billion grant represents a 25% cut to the grants paid to councils in 2010–11. Councils are faced with tough decisions, made according to local priorities.

Community budgets for families with complex needs represent a greater opportunity to more effectively support families with multiple problems whilst also using public funding more efficiently. Work in 16 first phase areas (28 councils) is already underway to improve the lives of these families via a community budget approach and many more councils are getting ready to join them in the next phase. The LG Group has made an offer of sector leadership, but councils cannot do it alone. These problems require local public services to work together in new ways, including pooling our resources. Central government’s agencies must be committed to play a full part in this work. This work currently largely focuses on interventions for the most troubled families in society, rather than a universal approach to early help, and there may not always be child protection concerns, but it illustrates how councils and local partners can work in different ways to provide support to families.
4. Factors affecting the quality of decision-making in referral and assessment, and variations across the country

Professor Munro also highlighted the inherent uncertainty and ambiguity in making predictions about children’s future safety. Risk can be managed, but never eradicated; low probability events do happen.

There are factors that may affect the quality of decision making in referral and assessment. Social workers’ caseloads and their skills and experience will naturally affect decision making, as will how effectively they are supported, for example by managers who have strong analytical and risk assessment skills. In recent years there has been a well-documented consistent rise in the number of referrals and care applications, alongside a significant recruitment problem in the profession. Work is being done by the Children’s Workforce Development Council and Social Work Reform Board to address the recruitment problems seen in recent years and to ensure that the training of social workers better prepares them for the realities of practice.

The fear of missing a case of a child at risk has led to a rise in number of referrals to social workers, the majority of which are not deemed to warrant a full child protection investigation. Clear, well-understood and accepted procedures will also support effective decision-making. Some areas have introduced multi-agency teams to better address some of the challenges in referral and assessment. The specific model is less important than the effective engagement of and communication between local partners.

5. Appropriate thresholds for intervention, including arguments for and against removing children from their families

Thresholds for intervention can sometimes be a cause of disagreement between agencies. As described above, there is natural anxiety about the nature of the work that can contribute to this. Multi-agency teams that bring together all the information about a family are one way that an increasing number of councils are adopting to address some of the challenges faced in making these decisions and that referrals are responded to in an appropriate way. This approach effectively acts as a triage system at an A&E department, and requires experienced staff to assess seriousness.

Some children will need to be removed from their families; good assessments are crucial to inform this. The Munro Review highlighted concerns about over-prescriptive guidance on assessment and that the standardised process does not always act in the best interest of the children.

The court system of course plays a crucial role in decisions about removing children from their families. The interim report of the Family Justice Review identified many problems with the way the system operates and we await the recommendations of the final report and the Government’s response with interest.

6. Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

The role of non-social work agencies in child protection cannot be underestimated, as highlighted throughout this submission. Different priorities and cultures of different agencies mean that there are sometimes areas of professional tension and disagreement. However, if conditions for good multi-agency practice are in place, these potential problems can be overcome.

Working Together to Safeguard Children is the key piece of guidance on inter-agency working. It is currently being reviewed following the recommendations of the Munro Review, a piece of work that the LG Group welcomes and is involved in.

Local Safeguarding Children Boards have an extremely important role in bringing partners together and calling them to account. They can provide clear procedures and make available multi-agency training.

Ofsted’s proposed new arrangements for inspection of children’s services provide a welcome recognition of the contribution of all local agencies; however it is unclear how effectively multi-agency working will be achieved without being able to make judgements on agencies other than the council. One proposal to achieve this is to have increased focus on the role and effectiveness of LSCBs. The Children’s Improvement Board is developing some work on what an effective LSCB looks like.

November 2011
Written evidence submitted by Professor June Thoburn, University of East Anglia

1. I am a Registered Social Worker and worked in child and family social work in England and Canada before moving to the University of East Anglia in 1980. As a founding Director of the UEA Centre for Research on the Child and Family and of the Making Research Count collaboration, I have a particular interest in finding innovative ways of helping social workers and other child welfare professionals to use knowledge from a range of sources in their practice. My teaching and research have encompassed family support and child protection services for children and families in the community and services for children placed away from home, in the UK and internationally. I am frequently asked to provide expert evidence (in the UK and abroad) in complex child welfare cases; have contributed to Judicial Studies board training and was a member of the President of the Family Division’s interdisciplinary committee on family justice. I was until recently Vice Chair of the GSCC and Chairperson of the Jersey Child Protection Committee and was appointed to the Board of Cafcass in May 2009. I was a member of one of the working groups contributing to the Munro report on child protection (looking particularly at data issues, quality assurance and inspection) and of the Social Work Reform Board sub-committee on the Education and Training of Social Workers.

2. Publications and research reports of particular relevance to this memorandum are:
   - Effective interventions for complex families where there are concerns about or evidence of a child suffering significant harm—a research synthesis completed for C4EO (Centre for Excellence and Outcomes in Children and Young People’s Services). A refereed Journal Article based on this is attached to this memorandum (Thoburn, J (2010). “Towards knowledge-based practice in complex child protection cases: a research-based experts’ briefing”. Journal of Children’s Services Vol 5 Issue 1 March 2010 pp 9–24).

3. With UEA colleagues I recently completed a process and outcome evaluation of one of the 15 Think Family Pathfinders that have informed recent government policy on improving the life chances of children living in families with complex and multiple problems.

4. Informed by this research, the major thrust of this memorandum is that it is essential to differentiate, when discussing effective child protection interventions, between:
   - early help in the lives of young children and their families;
   - early help to prevent problems in the lives of children and their families from escalating to the point when formal child protection services become necessary; and
   - effective ways of intervening once there are serious child protection concerns, and especially with families with complex and multiple difficulties, who are “hard to reach” or “hard to change”.

5. Whilst the Tickell, Field and Allen reviews present ways forward with respect to the first two of these, I consider that the evidence does not support the applicability of these to families with complex problems. Indeed, the term “early intervention” is misleading.

6. Whilst there is evidence that the “model programmes” listed in the Allen review as “proven to be effective” do produce benefits for parents who are beginning to struggle, especially with children with challenging behaviour, the evidence is not there that they are effective once children have suffered neglect or other forms of maltreatment, and especially with “hard to reach” and “hard to change” families.

7. My review (attached) of “what works” with families with complex problems identifies the essential elements of practice that have the best chance of being effective. Foremost of these are flexibility of approach and intensive intervention by workers who are able to gain the trust of family members by providing a combination of practical help, sound advice and emotional support. Clarity about what may happen if necessary improvements to children’s lives are not achieved has to go alongside tackling practical problems that impact on the quality of life of the family as a whole. Although aspects of “model” programmes developed in other jurisdictions (including those listed in the Allen report and being “rolled out” by recent government initiatives) form part of the “tool kit” of effective workers who comprise the “teams around the families”, the key to
success is flexibility of approach in the light of the particular issues for each family. The “programme fidelity” urged by the originators of these programmes does not “work” with families with complex problems in which children have already experienced maltreatment or are already on the edge of care. Nor is it clear that model programmes developed in other jurisdictions can appropriately be used “off the peg” with highly vulnerable families in disadvantaged areas of England.

8. Other essential elements of services that are most likely to be effective with families with complex problems which place their children at substantial risk of maltreatment are:

- most services are provided within the family home rather than in group or clinical settings; and
- the direct service is provided by a lead professional for the child (usually a Children’s social care social worker) and a different lead professional for the parents, supported by specialist professionals who advise either the lead workers or the families themselves depending on the case.

9. It is also important to note that, when children are recognised as suffering harm or out-of-home care is being seriously considered, intensive intervention, provided at a “critical” or “turning” point, when parents and older children recognise that they need help, can have a positive impact. However, in only a small proportion of the cases in our recent study was it possible to close the case within Children’s social care services when the period of intensive intervention ended. What the intensive intervention service was able to achieve was to move families forward to making better use of Children’s social care child protection or locality team services, as well as “universal” services. In some cases it resulted in a decision for children to enter care, but this could be achieved in a planned and less traumatic way than is usually the case.

10. I have serious concerns about the “payment by results” approaches being applied to services for maltreated children, children on the edge of care, and their “hard to reach” or “hard to help” families. A “good result” will be different for each child and each family. For some, a well planned entry into long term care or adoption, arranged with no unnecessary placement changes in care, will be a good result; and for others a temporary therapeutic or respite placement in care will be a good outcome. So prevention of entering care must not be seen as a “good result” triggering payment.

11. Equally, Children’s social care being able to “close the case” cannot be seen as an appropriate outcome when measuring the effectiveness of a service. Some families will need at least an “episodic” “tier 3” social care or voluntary sector service until all the children are grown up, with the timely resumption of high intensity services at times of stress, if children are to remain safely with parents who have been abusive or neglectful. There is evidence that neighbourhood family centres are able to provide lower intensity, longer duration or episodic services to families with long term and complex problems in which children are at risk of harm. Sure Start Children’s Centres have a great deal to offer if they work closely with statutory child protection and family support services, but their effectiveness in this role is limited because of the age restrictions. Some are already moving towards a mixed age family centre model and this is to be encouraged and should be evaluated.

12. Equally, judging outcomes by length of time in care is not appropriate. Whilst there is some scope for earlier decision making so that very young care entrants can be placed more quickly for adoption, once children have suffered maltreatment, it has to be recognised that return from care is the least successful “permanence” option. It has, of course, to be the first option (alongside placement with relatives), but the evidence does not support the widely held view that out-of-home care is an option to be avoided.

13. Given the age profile of care entrants, the fact that many are members of sibling groups, have challenging behaviour and indeed do not wish to be adopted, the scope for increasing adoption as a route out of care is limited. It is not widely acknowledged that UK social workers succeed in placing more children from care for adoption with new parents not already known to them than is the case for any other country. (More children leave care via adoption in the USA but a large proportion are adopted by relatives—a practice not encouraged in UK nations because of issues around confused identity.) It is of course essential to ensure that children in long term care have stability, continuity and a sense of permanence. Most maltreated children who need to enter care, and who stay for longer periods in stable foster or (if older) residential placements, have better outcomes than would have been the case had they remained with the maltreating parents (unless very substantial and prolonged assistance is provided, which is often not the case). Although there are still too many cases where stability and a sense of permanence is not achieved, the 2008 Children and Young Person’s Act will do much to cement the progress that is already being achieved in securing greater placement stability and better outcomes.

14. Finally, I respectfully suggest that the questions posed by the Committee appear to be overly focussed on “assessing” and “thresholds”. Essential though this is, assessment on its own does not keep children safe, or help their parents to make changes and promote their wellbeing. The assessment process has to go alongside appropriate helping, provided from the moment that the possibility of maltreatment is recognised, and modified in the light of re-assessment as circumstances change.
Further written evidence submitted by Professor Thoburn, University of East Anglia

TOWARDS KNOWLEDGE BASED PRACTICE IN COMPLEX CHILD PROTECTION CASES: A RESEARCH-BASED EXPERTS’ BRIEFING

ABSTRACT

The paper is an extended version of an “experts’ briefing” commissioned to inform senior child welfare managers in English local authorities and voluntary agencies about the available evidence to inform the provision of effective services in complex child protection cases (Thoburn and Making Research Count, 2009). Apart from the consistent finding from clinical practice and qualitative research studies about the centrality of the professional relationship, the author concludes from a review of research that no one service approach or method has been robustly evaluated as effective with “complex” families where there is evidence of maltreatment. The author argues that a combination of services and interventions will usually be needed in these complex cases. To date, only a small number of interventions has been evaluated by experimental methodologies in terms of their effectiveness in preventing reabuse, usually at an early stage of identification of child protection concerns. The paper argues that adaptations to the UK context of these promising model programmes should continue to be evaluated. It also refers to the UK process and longitudinal research which indicates that “home grown” approaches and methods that have not been shown by experimental method evaluations to make a statistically significant impact on child wellbeing should not be automatically viewed as “ineffective”. “Service as usual” approaches as well as adaptations made to “model” programmes should be carefully evaluated using research methodologies most appropriate to the service model and type of maltreatment or family the service is designed to assist.

INTRODUCTION

This paper focuses on UK children who are assessed as (or would be if they were referred or referred themselves for assessment) “children in need” (whose health or development is likely to be ‘significantly impaired’ without the provision of [an additional/targeted social care] service” (Children Act 1989 Sec 17b) or child protection enquiry (CA 1989 Sec 47). The children and their families will be receiving, or ought to be receiving, “specialist” services (as defined in Every Child Matters, Her Majesty’s Government, 2003) to prevent further harm or reparative services at “levels 3 or 4” (Hardiker, 1991, Garbers et al, 2006). However, it is argued in this paper that these services have the best chance of being effective if they are integrated with high quality level 1 and level 2 services (“universal” and targeted at potentially vulnerable families).

“Effectiveness”, for purposes of this paper, is defined as the prevention of further maltreatment or significant impairment to the child’s development. This includes child wellbeing outcomes but also “service output” measures—the extent to which appropriate services are offered and taken up to ensure that the child’s needs are met in a way which is likely to enhance their opportunity to grow and develop as they move through childhood into adult life. With vulnerable children the five Every Child Matters wellbeing dimensions7 map onto the dimensions and domains for individual children and their families in the Assessment Framework “triangle” (DH et al, 2000), including a “sense of permanence” and a sense of cultural and personal identity (Parker et al, 1991; Thoburn, 1994).

This paper is an extended and more fully referenced version of one of the “experts’ briefings” being commissioned by the English Department for Children, Schools and Families (DCSF). It does not set out to be a literature review and did not involve a web-based search: the tight four month time scale precluded such an approach—but draws on published literature reviews and research syntheses and other work in which the author has been involved (including the recent Lancet Special issue on safeguarding children research (The Lancet, (2008)). The briefing also draws on comments on early drafts of academic colleague specialists on different aspects of child protection practice and research and on the comments of independent reviewers. The secondary sources on which it draws also include practice texts (mainly by USA and UK social work academics). Any claim to originality lies in its purpose: namely to guide managers, commissioners and service planners, many of whom will not have had the benefit of training in research literacy or research methods, through the complex knowledge base relevant to child protection, including the “wicked” issue of how to improve the effectiveness of the services they provide in complex child care cases. The term “complex child protection work” was that of the research commissioners and is further defined in the sections which follow.

SCOPING THE RELEVANT SERVICES AND RESEARCH

Maltreatment is multi-faceted and different service approaches are likely to be effective with different types of family at different stages of recognition of actual or likely maltreatment. As a necessary consequence, the body of research is diverse, multi-faceted and multi-method. In this paper the UK and international research (mainly from the USA) is flagged up. It is important to point out that differences in the approach to service provision in different jurisdictions impact on both the nature of research conducted and its transferability across national boundaries (Thoburn, 2007; Gilbert, 1997; Boddy et al, 2009a; Ruffolo et al, 2009).

Services in England, as in other EU jurisdictions, are based on the UN Convention on the Rights of the Child (as interpreted in England by the CA 1989 and subsequent children legislation). The approach is one of

7 Being healthy; staying safe; enjoying and achieving; making a positive contribution; economic well-being.
One or both parents will usually have one and often several of the following characteristics:

- Way which achieves and maintains necessary change for the child (referred to in this paper as “hard to change”).

For the purpose of this briefing “complex” was taken to refer to the children most likely to be maltreated (see for example Sidebotham et al., 2008). Barlow and Schrader-MacMillan (2009) relate the evaluation literature to families where there is concern about emotional abuse.

In contrast, although there is a very large body of relevant UK and European research (some of it referenced in this paper), most of it is process or “formative” research providing detailed information, from a usually small number of cases studied in depth, on the characteristics of those using the services and on the services provided. Those which provide outcome data tend to use “change over time” measures for cohorts of children, rather than comparing those who have been provided with the intervention with those who have not. They are also more likely to use parents’ and increasingly children’s satisfaction (Morgan, 2007) with the different aspects of the services provided (or not provided) alongside child wellbeing outcome measures. Some use quasi-experimental methodologies (including longitudinal designs often with longer follow-up intervals than are usually achieved with experimental methodologies). However, given the lack of a control group and the usually multi-faceted nature of the services provided, sometimes over a period of years, findings from these studies are reported in terms of specific methods or interventions. This contrasts with the USA, where much of the relevant “what works” research has been conducted.

Families whose needs are ESPECIALLY COMPLEX

There is broad agreement about the characteristics of parents who are likely to maltreat their children and the children most likely to be maltreated (see for example Sidebotham et al., 2001; Sidebotham and Herron, 2006; Social Exclusion Task Force, 2007). For the purpose of this briefing “complex” was taken to refer to families who become known to the social care services because their children have been harmed or are considered likely to be harmed, but who are particularly difficult to engage “hard to reach”, or to help in a way which achieves and maintains necessary change for the child (referred to in this paper as “hard to change”). One or both parents will usually have one and often several of the following characteristics:

- Are isolated, without extended family, community or faith group support;
- Were abused or emotionally rejected as children or had multiple changes of carer;
- Have a mental illness and/or a learning disability, especially if no other parent or extended family member is available to share parenting, and combined with a child who is “hard to parent”;
- Have a personality disorder;
- Have had several partners often involving an abusive relationship;
- Have an alcohol or drug addiction and do not accept that they must control the habit for the sake of their child’s welfare;
- Have aggressive outburst, a record of violence, including intimate partner violence;
- Have obsession/alarming controlling personalities, often linked with low self-esteem;
- Were in care and had multiple placements or “aged out” of care without a secure base (potentially mitigated if they had a good relationship with a carer, social worker or social work team who remained available to them through pregnancy and in early parenting);

See for example the Brandon et al (2008) eight year follow up of a total cohort of 105 children allocated to child protection social worker caseloads, or the Hunt and MacLeod (1999) follow-up study of judicial decisions in a cohort of child protection cases.
Some children and young people have characteristics which make them “hard to engage” or “hard to help/change” and, when combined with one or more of the above parental characteristics are most vulnerable to continuing harm:

- Children born prematurely and/or suffering the effects of intrauterine drug and/or alcohol misuse, which can make children fretful, hard to feed and unresponsive;
- Children with disabilities or other characteristics which make them hard to parent or “unrewarding” in the eyes of parents who lack self esteem and confidence;
- Individual members of sibling groups “singled out for rejection” (Rushton et al 2001) and/or targeted for abuse;
- Children returning home from care, especially if they suffer the loss of an attachment figure (usually a foster carer)—several recent studies have demonstrated that children who return to a parent following more than a short period of planned care are more likely to be re-abused than those who remain in permanent foster care, are placed with relatives or are adopted (Taussig et al, 2001; Sinclair et al, 2007; Brandon and Thoburn, 2008; Farmer, 2009);
- Teenagers (many of whom have suffered from unrecognised or un-responded to abuse or neglect) who engage in risk-taking or anti-social behaviour. (Stein et al, 2009).

When considering the likely impact of interventions, a key “family type” dimension is willingness to seek out or be referred for a service and then willingness or otherwise to work collaboratively when services are offered (often referred to as “co-operative” or “uncooperative” families). Overlapping with this are the family dimensions identified by Cleaver and Freeman (1995) when researching parental responses to suspicion of abuse (and since adapted by DH/DCSF for data collection purposes—National Statistics and DCSF, 2008a, 2008b). Using these broad family needs groups, Thoburn et al (2000) found that 25% of families of children under eight provided with a service under section 17 of the CA 1989 in three authorities were families with “long standing and multiple difficulties”: 10% were families in “acute distress”; 40% were “single issue” families and 20% had a short term problem. For a cohort of families of children all of whom were assessed as suffering or likely to suffer significant harm, Brandon et al (1999) found that 40% had long standing and multiple problems, 25% were in the “acute distress” category; and 32% were in the “single issue” group, including 5% of cases where the concern arose because of an “infiltrating perpetrator”. Little et al (1999) and Ghate and Hazel (2002), using empirical research on community samples of families experiencing stress, identify similar “needs groups”. These categories are returned to in later sections when considering the effectiveness of services for different types of family, but the central point (of particular relevance to service planners) is that a knowledge-based audit of the proportions of families in these different broad “family-type” or “needs” groups will lead to the necessary differentiation of service approaches and more effective use of resources to prevent further maltreatment. In particular different patterns of service intensity and duration are likely to be more or less effective with different sorts of families.

**Over-arching Characteristics of Effective Services to Families with Complex Problems**

For each of the professions involved in child protection work there is a large volume of literature describing the essential elements of effective professional practice (see, for example *The Child Protection Handbook* edited by Wilson and James, 2007). These are briefly summarised here with respect to an effective social work/social care service, although many of the characteristics are common to other professionals involved in child protection work. Broadly, the task can be divided into effective assessment and decision making and effective helping.

*Effective assessment and decision making*

A regularly reviewed comprehensive assessment has to be based on “here and now” observations but also on a psycho-social history of all family members and their relationships. In this respect, the move to greater use of family group conferencing (although the research on effectiveness in terms of child wellbeing outcomes is not yet robust—Vesneski 2009) is likely to result in a fuller picture of the family’s history and relationship patterns (Morris et al, 2008). The Assessment Framework statutory guidance and the “needs triangle” (DH et al 2000; Parker et al, 1991; Rose, 2001) are based on research from child development and other relevant disciplines. The assessment process needs to lead to a conclusion not only about the type of and responsibility for the maltreatment, and its impact on the child, but also on the overall pattern of family functioning. The decisions about the approach to service provision, and the specific methods/service components that have the best chance of being effective, have to be based on this analysis, although periodic reassessment is needed to catch changing circumstances and to avoid the problems associated with “crude” stereotyping (Burton, 2009; Fish, 2009).
Deciding whether compulsion is needed in cases where there is continuing risk of harm

A major question as soon as the possibility of significant harm to a child is identified is whether it will be possible to work collaboratively with the parents or whether an element of coercion (through the formal child protection procedures or the family justice or criminal courts) will be required. Several research studies have explored the “partnership—compulsion” dimensions of practice (eg Thoburn et al, 1995; Bell, 2002; Calder, 2008). English government statistics demonstrate that there are major differences between similar authorities in the rate at which children’s names were placed on the child protection register (post-2008—“have a formal child protection plan”) (National Statistics and DCSF, 2008a, 2008b) and use care orders rather than placement at parental request or with parental agreement when children need out of home care (Dickens et al, 2007; Packman and Hall, 1998). Pugh (2007) found significant variations by gender, age, and local authority, in the periods of time that children had a child protection plan, both between, and within, authorities. Differences in the use of coercion in child protection work are even more apparent across national boundaries (Gilbert, 1997; Katz and Pinkerton, 2003 Thoburn, 2007).

The majority of parents and carers who significantly harm their children do not set out to do so, and most can be assisted to play a meaningful part in their children’s lives (even if they can not provide safe full time parenting). When considering the key dimension of ability and willingness to work collaboratively with the protective and support services it is important to differentiate between, and respond differently to three groups.

— Within the totality of families where there are child protection concerns, those who are “uncooperative” because they actively set out to inflict pain or otherwise harm a child in their care are comparatively few in number. They either avoid contact with agencies, or adopt an attitude of false compliance. For these, the only effective intervention is to provide a professionally skilled and authoritative service leading to early recognition of their intention and place the child in an alternative family or remove the offender and support the remaining parent (if there is one and he or she is able to keep the child safe).

— There is a larger number of families who are concerned for their children’s wellbeing but, at least at times, do not work collaboratively and/or do not realise they are harming their children. These include parents who are fearful of losing control; have no confidence that social workers/other professionals can help rather than make things worse (possibly because requests for help in the past have been inappropriately responded to); or do not recognise the need to give up a drugs habit or leave a violent partner.

— Some parents (overlapping with the second group) who have immature or controlling personalities or multiple needs of their own often fail to recognise the needs of their child or have beliefs about the benefit of harsh physical punishment.

All three groups are likely to seek to deceive workers. Lies, attempts to avoid contact, or “false compliance” are to be anticipated but strategies to deal with this sort of behaviour will differ because the relationship between the child and parents (and attachment patterns) is likely to be different (Howe, 2005; Stevenson, 2007a). The evidence from some studies is that, if provided with an appropriate service, parents in the second two groups can become engaged and the need for coercive measures will reduce (Thoburn et al, 1995; Farmer and Owen; 1995; Brandon et al., 1999). More recently there has been corroborative evidence of this from the intensive family support projects highlighted in Think Family (Social Exclusion Task Force, 2007; Morris et al, 2009), and that “uncooperative” parents and adolescents can be encouraged to become engaged with professionals if the services provided seek to meet all their needs and do not focus more narrowly on risk factors or anti-social behaviour. The move from the procedure of “registering” the child on the child protection register to the “recording of a formal child protection plan” was supported by research which found that the stigma of “being registered as an abuser” led to a preoccupation (for parents and workers) with “getting off the register” rather than meeting the needs, including the protection needs, of the child (DH, 1995b). There is as yet no research to indicate whether this change of discourse has led to a change of professionals’ practice and parents’ willingness to engage with the protection plan.

Principles for effective helping and protection

Central to effective helping and achieving necessary change, whatever specific method is used, is the availability, for parents and children, of a dependable relationship with at least one authoritative professional who can be trusted to provide reliable information about problems and processes, and to always keep the child in mind whilst actively pursue creative and flexible ways of helping all family members. Effective joint working between professionals is essential, but the evidence that structures and systems can in themselves secure effective decision making and joint working is weak (Hallett, 1995; Glisson and Hemmelgarn, 1998; Glisson, 2007; Ward et al, 2004; University of East Anglia and National Children’s Bureau 2007; Audit Commission, 2008).

The complexity of providing a dependable professional relationship in many of these situations in which parents will seek at times to conceal or minimise their difficulties, is highlighted in research studies and practice commentaries based on them (Buckley, 2000; Jones, 2001; Munro, 2000; Cooper et al, 2003; Howe, 2005; Stevenson, 2007b; Calder, 2008) Often, in these complex, high risk, situations, this will require a different professional working with the child and the parents (sometimes a different professional for each parent or member of a sibling group). Whilst the child’s welfare must always be the paramount consideration, those
working with parents who have complex needs of their own must be able to offer them a dependable professional relationship and skilled and knowledgeable assistance. Co-working in these “team around the child and family” cases requires vigilant, challenging, knowledgeable and empathic co-ordination and supervision of all workers and volunteers (Burton, 2009). When this approach is used, “professionals’ meetings’ will be needed (alongside “core group meetings” and child protection conferences involving family members) to ensure that parents are not able to draw “their” allocated worker into collusive situations resulting in loss of focus on the child. Other models which can work well are a single worker with a very small case-load and 24 hour availability of supervision/consultation, as in the intensive family preservation models developed in the USA (Schuerman et al., 1994) and adapted in some agencies in the UK, including some of the family intervention projects (Brandon and Connolly, 2006; Social Exclusion Task Force, 2007). A co-working model, with two workers sharing the lead professional role for the family as a whole is another possible approach developed from family therapy.

The essential elements of relationship-based psycho-social casework (combining elements of care and control) are spelled out in the texts already referred to and are based on evidence from research studies that services are unlikely to be effective if parents and children do not consider that they are treated with honesty and respect as a minimum, and cared about as individuals with needs of their own (as required by the Principles and Practice guidance published with the Children Act 1989 and the guidance on working in partnership (DH, 1989, 1995a)). With some of the most emotionally scarred or mentally ill parents and adolescents it may not be possible to achieve a trusting professional relationship, and it is in these cases that family members may withhold the truth or deliberately tell untruths. It is only when skilled and committed workers have time to spend with and empathise with these parents that it becomes possible to understand when important information or serious problems are being concealed and more intrusive measures to protect the child are needed. In these cases, to ensure that the child’s welfare remains the paramount consideration, the role of an equally skilled and knowledgeable casework supervisor becomes even more vital (Woodhouse and Pengelly, 1991; Brandon et al., 2008, 2009; Burton, 2009)

When provided alongside this relationship or “therapeutic alliance” a range of approaches to helping and therapy can be effective. Much present day child and family welfare practice (including some promising programmes such as multi-systemic therapy being trialled in the UK) draws on an “ecological” or “person in environment” approach (Bronfenbrenner, 1979; Jack and Owen, 2003). Services for families with complex needs will, in most cases be multi-faceted, and will usually involve the provision of practical help alongside more defined interventions to address identified problems. The Framework for the Assessment of Children in Need and their Families (DH et al 2000) and the research overview The Children Act Now: Messages from Research (DH, 2001) emphasise the importance of discussing with families ways of providing immediate assistance (which is often of a practical nature) alongside the assessment process.

Within this broad approach to service delivery a wide range of specific methods and interventions has been shown to be “effective” or “promising” with respect of specified difficulties which may be present in maltreating families and at the early stages following problem identification. However, MacMillan et al (2008) conclude that, once serious or prolonged maltreatment has occurred, there is no robust evidence that any one intervention is effective in preventing further maltreatment in families who have complex needs Some broad messages about promising approaches and interventions are now discussed in the context of the different groups of hard to reach or hard to change families Many of the studies referred to are included within the DH/DCSF programmes of research widely disseminated through the Messages from Research publications going back to the 1995 Child Protection: Messages from Research project. (See especially DH, 1995, 2001; Quinton, 2004; Beecham and Sinclair, 2006; Stein, 2009; DCSF, 2009) all of which summarise messages about practice that has a reasonable chance of having a positive impact in some cases where child protection concerns have been identified.

Effective Approaches to Helping Families and Young People who are Hard to Identify or Engage

Knowing about promising interventions and approaches to supporting families and protecting children is of little assistance if the family is not known to the agencies with safeguarding responsibilities and resources.

Hard to reach parents include some who are aware that their behaviour would be judged as harmful to their children (including those with addictions who do not wish to or are unable to give up their habit, or parents aware that their abuse by a violent partner is damaging to a child but are unwilling or too fearful of the

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89 The Schedules to the Family Support sections of the Children Act 1989 list a range of practical services that can be provided to ‘a child in need’ and their family, including help with holidays, a laundry service if the child has a disability, and ‘in exceptional circumstances’ a cash payment. Assistance in finding more suitable housing, or claiming welfare benefits, subsidized day care, and help with domestic tasks are often sought by families and provided as a package of services. Defined interventions may include attendance at a parenting group, an anger management course or a programme of detoxification and testing for evidence of continued use of illicit drugs.

90 The terms are used here in the generally accepted sense that, to be considered ‘effective’ there must be robust evidence that any improvement in outcomes did not happen by chance—usually demonstrated by random allocation to ‘intention to treat’ or ‘service as usual’ groups. ‘Promising’ is used for clearly defined interventions for which soundly conducted evaluations have identified associations between desired outcomes and well documented service received, but for which experimental evaluation methods such as the RCT are either inappropriate or have not yet been used; or results of experimental evaluations are inconclusive or inconsistent.
consequences to seek help). They are likely to devise strategies for concealing any difficulties for their children from the “tier 1 or 2” professionals such as health visitors, GPs or teachers or to convince these professionals that they are able to protect their children. Isolated single parents whose children become victims of “infiltrating perpetrators” of sexual or physical abuse, may also be reluctant to seek help, because recognising and talking about any suspicions is likely to mean they will be on their own again.

Stanley et al (2009) emphasise that, with parents who have a chronic or recurring mental illness, and with those where there is domestic abuse or addictions, fear that contact with statutory services will result in children being removed from their care frequently creates a barrier to engaging with services for parents as well as for children who have taken on a caring role. These writers note that these experiences are highly stigmatising and parents and children are unlikely to disclose them readily. Practitioners in universal services, including primary and acute health services and in adult social care need to be prepared to raise questions about such issues on more than one occasion and to adopt attitudes that are respectful and non-judgmental rather than blaming or punishing. Open discussions of alternatives, including of the possibility of a child being provided with out-of-home care on a short or longer term basis, can promote rather than deter engagement with the children’s social care services.

The fear of stigma is another powerful factor deterring other groups of families from seeking help as difficulties emerge. This applies especially to some minority ethnic groups (Brophy, 2003; Thoburn et al., 2005). Hard to reach parents also include those who appear to be coping well but where a low threshold for tolerating stressful events can result in a violent outburst, or attitudes to parental control, child compliance and the use of physical methods of control may result in a one-off incident that can cause death or serious injury, especially to a small child. Gilbert et al (2008) cite international research demonstrating that many maltreated children are never identified by the universal services and referred on to the formal child protection services. Even at the most serious end of maltreatment, Brandon et al (2008) conclude that between 30% and 40% of the children about whom a serious case review was initiated following death or serious injury had not been known to children’s social care within the previous two years. Although any one of a number of professionals in the health, police, education, housing or income maintenance services may be aware that a parent or child is experiencing difficulties, in an (unknown) proportion of cases they fail to refer the family for specialist services to safeguard the child from the abuse they may be suffering.

This is especially the case with respect to children suffering as a result of neglect, and can apply equally to teenagers as to younger children. Five of the 11 studies in the Safeguarding Children Research Initiative (DCSF, 2009) focus on neglect and emotional maltreatment. Stein et al. (2009) point to a growing body of evidence that teenagers exposed to neglectful parenting are both less likely to be referred and less likely to refer themselves for a child protection service. Daniel et al. (2009, p.1) have reviewed the literature on neglect, focusing especially on what is known about how parents and children indirectly indicate their need for help. They emphasise the research evidence on “the overwhelming impact of poverty” and the “corrosive power of an accumulation of adverse factors”. They conclude that efforts should move on from identifying the impact of neglect (now more widely acknowledged in policy and practice) and the search for predictive tools. Instead, they argue that resources should be put into developing the assessment skills of front-line professionals and training on the characteristics of parents, children, and environmental circumstances that contribute to neglect. In particular they advocate training in communication skills which facilitate conversations with parents and children, including asking direct questions about, for example, the impact of a drug habit or a mental health problem on a child (a point also strongly made by Ayre, 1998; Poblete, 2002 and Jones, 2006). This is in line with other studies and literature reviews which point to the problems inherent in relying on risk assessment tools (sometimes used in a “one-off” interview) as predictors of maltreatment since they identify many families who will not maltreat their children and fail to identify some who will go on to seriously abuse them (Baird and Wagner, 2000). However, such tools (including those listed in the appendix 3 of Working Together—HMG, 2006) may be helpful in identifying vulnerable parents and children who may benefit from assistance (Schlonsky and Wagner, 2005; Munro, 2005).

In a small but illuminating study of the role of GPs in child protection identification and helping, Tomsett et al. (2009) identify the conflicts perceived by some GPs who provide a long term service to all family members. They particularly note that GPs tend not to speak directly with children, even when they have suspicions about maltreatment. Like other researchers who have identified reasons why some health care personnel in hospitals as well as the community, fail to make referrals (Gilbert et al., 2008) they point to a lack of confidence that the referral will result in a service, or anxiety that it will be responded to in a way which results in the family withdrawing even from primary care services.

Outreach youth workers are well placed to encourage teenagers who have suffered abuse or neglect (and often engage in risky behaviour) to seek assistance if they give out hints about maltreatment of neglectful parenting (Stein et al., 2009). Kids Company, with its combination of a welcoming drop in service and assertive outreach by key workers (Gaskell, 2008) has a very high rate of self referral from vulnerable young parents and teenagers.
APPROACHES AND METHODS most likely to be EFFECTIVE with FAMILIES who are “Hard to Help” or “Hard to Change”

Reference has already been made to research on family types, recognition of which can lead to early decisions around duration and intensity of the service needed as well as a plan for the specific methods that may be appropriate.

Looking first at broader approaches to work-load allocation that are most likely to provide a framework for effective practice with families with whom change is hard to achieve or maintain, parents and young people emphasise that, although some welcome a change of social worker for reasons they are able to explain (usually a less than adequate service), most look for continuity. For this reason, as well as in order to provide for more continuity in professional networks, the move that has occurred in several English local authorities from a functional model to a community-based model of case allocation is supported by research. However, increasing the availability of social support to these especially vulnerable families acts as a supplement to rather than a substitute for a social casework service (Gaudin, 1993; Ghate and Hazel, 2002). Tunstill and Allnok (2007) have identified models of practice which lead to a better integration of child protection services between Sure Start children’s centres and targeted child and family services for families referred because of child protection concerns. An important contributor to those centres that were more successful in this respect was the attachment of a child and family team social worker who modeled the link between generally available services and specialist child protection and out-of-home care services.

Berry et al (2006) and Tunstill et al (2006), using a wider range of what Berry refers to as “sensitive outcomes” or “steps along the way” than is used in experimental-design research91 provide evidence that neighbourhood family centres, combining drop in support and parenting training with “targeted” outreach services, can be particularly successful in working collaboratively with some families with very complex problems. The services provided include practical assistance (including financial support and subsidised day care), educative and therapeutic group work for parents and children and relationship-based casework. The centres are well positioned to “hold the ring” between family members’ support and protection needs, possessing sought-after knowledge about the needs and preferences of parents; experience of the tasks involved in constructing local service networks; and possessing skills in joint working. This is in line with the (mainly descriptive) evaluations going back many years of the work of Family Service Units (Cook and Miller, 1981; Martel, 1981) which combined a centre base with intensive outreach work. More recent examples within the voluntary sector are the work of Kids Company (Gaskell, 2008) and Action for Children (Tunstill and Blewett, 2009) which provide “as long as needed” key worker outreach services with a drop in facility. In terms of more specialist needs, the outreach services provided by some women’s refuges and drugs actions teams are example of services which operate on similar lines.

These centre-based services have been reported to achieve improved parenting both for families needing a shorter term high intensity service and those who need a lower intensity, longer duration service. Parents and children form a relationship with the centre as a whole, which can facilitate the provision of a cost-effective “episodic” service. There is some evidence from a series of studies in the USA, UK, Scandinavia and Australasia that high intensity family preservation services are more effective in preventing long term family breakdown if they are preceded and/or followed by targeted lower intensity or episodic services, or if the same service has “permeable boundaries” so that families can re-enter the service of their own volition if stress levels rise again (Jones, 1985; Katz and Pinkerton, 2003; Munford and Sandberg, 2004). This can be particularly appropriate for families with long term and multiple problems, and also those with a “single issue” such as a recurring mental illness, or parents or children with a long term disability of health condition. Recognition at an early stage that a family will benefit from a lower intensity but longer term episodic service delivered from a familiar setting avoids the alienation often caused by repeated case closure and re-referral. It also represents a considerable saving of assessment time and peaks of high anxiety for parents and children (Thoburn et al, 2000).

An important aspect of the broad range of services accessed by families with complex needs is the provision of a planned foster care service for a child with challenging behaviour or a respite care service with the same “matched” family or group care resource. This can including parents with disabilities or mental health problems or addictions as well as the more commonly provided service to children with disabilities Packman and Hall (1998), Aldgate and Bradley (1999) and Greenfields and Statham, (2004) report that such a service is generally much valued by parents and children provided that they are fully consulted about the details of the service and involved in the matching process. These detailed process studies also provide evidence of reduction of stress and the possibility of using the increased “space” whilst the child is away for the parents to work on their problems. The “multi-dimensional” treatment foster care service developed in the USA (Chamberlain, 1990) and currently being trialled in the UK has been shown to be effective with children with challenging behaviour or offenders when there are parents or longer term foster carers who can become engaged with the programme whilst the young person is in out-of-home care (Biehal, 2009; and the literature review on interventions

91 In the UK, because there is a requirement in the legislation and guidance to seek to work in partnership with parents and children, parental and child satisfaction with the service is often used as a positive indicator alongside other more objective measures such as positive changes in child behaviour or parenting practice. A ‘sensitive outcome’ might be that a parent who has previously dropped out of several parenting groups, manages to complete a programme, or a parent reaches an agreement with social workers about a pattern of visiting a child in care and complies reasonably well with the agreed plans, thus reducing the separation anxiety of her child.
following physical abuse of Montgomery et al., 2009). Volunteer home visiting as with Home Start (Frost et al., 1996) and the Community Service Volunteers scheme (Tunstill, 2007) and carefully matched mentors supporting older children and young carers schemes are also resources that provide an element of supplementary parenting to children as well as support to parents.

Moving away from broader approaches and service settings, there is some evidence on specific methods and interventions that appear promising with particular groups of parents and children. Stanley et al. (2009) note that services to parents with mental health and addiction problems and families where there is inter-partner abuse have much in common. They point out that adult social care workers are likely to have extensive knowledge of these families and they may be able to offer families specialist interventions or additional resources relevant to their specific disabilities. Importantly some families perceive intervention from adult services, particularly those in the voluntary sector, as less threatening or stigmatizing. Learning disability mentors and advocates can be important members of teams around the vulnerable child and family.

There have been several experimental method evaluations of manualised and tightly defined interventions with families including some whose children are the subject of compulsory interventions. Although mostly developed in the USA (Webster Stratton and Herbert, 1999; Henggeller et al., 2002) or Australia (Sanders et al., 2003) the bets known have been or are being trialled in the UK and elsewhere in Europe (Barlow et al., 2008; Lindsay et al., 2008). When used in the UK with families with complex needs, these are often provided as one of a range of centre-based services or alongside social casework and other “team around the child” services (see for example Rose, et al., 2009; Tunstill and Blewett, 2009). The evidence for the effectiveness of these programmes with families with more serious problems including neglectful and abusive parenting, is not clear, placing them in the category of “promising” rather than clearly demonstrated as effective child protection interventions (McDonald, 2001; Utting et al., 2007; MacMillan et al., 2009; Ruffolo, et al.; 2009; Montgomery et al., 2009). Where the evidence of effectiveness is most robust is with respect to services for children and teenagers with a range of challenging behaviours some of which will have resulted from parental abuse or neglect. USA and Norwegian evaluations of multi-systemic therapy (MST) (Henggeler et al., 2002) have found this short term intensive programme to be successful with children and young people with challenging behaviour. The independent evaluation of MST projects being piloted in the UK will provide important information on how well this programme “travels” to the UK contexts. However, a systematic review of research (Littell, 2005, 2006; Littel et al., 2005) has questioned the robustness of the evidence and recent RCT evaluations in Ontario (Leschied and Cunningham, 2002) and Sweden (Sundell et al., 2008; Olsson et al., 2009) have found no significant difference between outcomes for the “treatment” and the “service as usual” groups, despite higher expenditure on MST services. These mixed results when model interventions developed in one jurisdiction are transferred across national boundaries, and sometimes with children and families with different or a wider range of problems, have prompted calls from their local evaluators for more research and evaluations to learn about aspects of the “service as usual” provisions that are associated with more effective outcomes. Whittaker (2009) and Garland et al. (2008) discuss approaches being adopted in the USA to identify the “common elements” of these interventions so that they can be used in a wider range of community-based services. Lindsay et al. (2008, p 159) report on their observational evaluation of three model parenting programmes being “rolled out” in the UK. They found positive changes for the majority of participants but no significant differences in outcome between the three evaluated programmes. Given substantial differences between the form and content they conclude: “it follows that other home-grown courses might be equally significant differences in outcome between the three evaluated programmes. 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about best professional practice across the disciplines. We are still some way from having a “menu” of methods known to be effective. Given the complexity of these hard to reach and hard to change families, an “approved list” approach is unlikely to be a productive way forward since it runs the risk of closing down on knowledgeable, flexible, creative and committed practice developments which have not yet been experimentally evaluated or for which experimental methodologies are inappropriate.

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November 2011
Written evidence submitted by BT

INTRODUCTION

1. BT is pleased to offer this short input to the consultation on the Child Protection System in England.
2. Our comments are restricted to providing information in response to the Committee’s question regarding online protection for children.

SUMMARY

3. BT is committed to providing a safe environment for children online. We have been involved from the beginning in a range of Government and industry-led initiatives on child safety.
4. We offer protection in conjunction with industry leader McAfee to all our broadband customers at no extra cost. We believe that applying controls to internet access devices (PCs for the purposes of this paper) currently offers the best level of protection for users.
5. We believe that the primary responsibility for children online lies with their parents and we provide the tools to do so, including parental controls software and educational material on staying safe online.

KEY ISSUES

6. There are potential dangers online but research shows that parental and broader support systems are functioning, with UK adult internet users being the most aware and active in Europe at protecting their children online.
7. BT has offered internet safety advice and free software to parents and children for many years and works with children’s charities to promote digital inclusion and in a range of other areas.
8. BT believes that currently PC-based controls are stronger and more flexible than network-based controls. Such controls also reinforce the message that parents (rather than an ISP) are responsible for their children’s safety online.
9. Our child-protection offerings are always evolving and we will continue to evaluate network-based parental controls. However, at this time these controls cannot match the functionality offered by PC-based parental-control software.

BT’S APPROACH TO CHILD ONLINE SAFETY

10. BT customers receive a parental controls package, provided in conjunction with industry leader McAfee, free with all BT Total Broadband packages and as part of a comprehensive offering of online security options, including firewall and anti-virus protection. All of our broadband customers receive a child protection guide with their home hub which explains how to set up their free BT child protection software and gives general advice on best practice for Internet safety.
11. BT provides a range of printed and online (www.bt.com/safety) advice to help parents keep children safe on the internet, including:
12. Our online safety advice has been updated recently, we have written to all existing broadband customers to remind them about parental controls, and we are committed to doing this annually.
13. All new customers are now required to choose between child protection settings being switched on or off when they use the installation CD provided to them when they first set up their BT Hub provided with our broadband services.
14. The service allows parents to:
    — block inappropriate websites;
    — set time limits for online usage;
    — get instant alerts when children attempt to gain access to blocked e-mails;
    — filter out websites not suitable for children by age range and category;
    — monitor and block programs such as instant messenger should they wish;
    — record and alert them to explicit postings on social network sites;
    — obtain regular reports of internet usage; and
    — restrict online gaming.
15. BT’s PC-based controls enable different levels of protection to be set on up to three devices in the home.
16. BT is proud of the work it has done to promote a safe online environment for its customers and, in particular, the safety of children online. We were founder members of ATVOD and the Internet Watch Foundation and the first to join Government initiatives UKCCIS and Get Safe Online.
17. BT believes that UKCCIS provides the right vehicle for identifying the issues of most relevance to online protection and a structure for bringing together all those involved (including Government, industry and children’s charities) in order to develop appropriate analysis of the issues and mechanisms for addressing them, where this is appropriate. BT is actively involved with UKCCIS and other organisations, either at board level or through specific campaigns. BT also works with children’s charities to promote digital inclusion and in a range of other areas.

18. It is also worth noting that BT is fully committed to making a positive contribution to society, recognising that by investing in and supporting our communities we can help to build a more economically sustainable, educated and socially-inclusive society. Part of our efforts in this is directed towards learning and skills, including developing skills for using the internet safely. Our active BT Volunteers programme contributes the time and skills of our employees towards learning and skills work, and our BT Internet Rangers initiative is all about encouraging and enabling young people to share their digital skills with older generations safely and confidently.

November 2011

Written evidence submitted by South Essex Rape and Incest Crisis Centre (SERICC)

1. I have been working within the Rape Crisis movement since 1992, initially in the role of volunteer counsellor, and full time since 2003. In addition to being a sexual violence specialist, I am trained in the treatment of trauma. Most of my therapeutic work involves helping survivors of sexual violence process their traumatic memories, build on their own strengths and resources, and move on with their lives. I work with both adults and young people, usually over 12 years old, but sometimes as young as six.

2. SERICC has been working with survivors of sexual violence since 1984, and between us the workers at SERICC have more than a century’s worth of experience in this field. From April 2010 to March 2011, SERICC received 8,637 sexual violence helpline calls, undertook 2,671 counselling and 2,668 advocacy sessions face to face, and received 801 letters and emails relating to work with our service users. SERICC covers the relatively small area of Thurrock, Brentwood, Basildon and Billericay.

3. The vast majority of SERICC’s work involves supporting adult survivors of childhood sexual abuse. This sort of abuse generally involves physical and emotional abuse too, and takes enormous resilience and strength to overcome because of the trauma it causes to the child.

4. Being believed, and receiving timely support are among the most important needs of a child disclosing abuse. These are the two things most often missing in the histories of the adult survivors we support. We still find that children and young people are disbelieved or silenced when they try to disclose, and that referrals to our service are not made by statutory services routinely. Thus, there are many children and young people who are not being offered any form of support despite disclosing what they have been through.

5. We know that parents, especially but not only mothers, whose own experience of childhood sexual abuse is known to Social Care, are often the target of unhelpful and even punitive intervention, to the extreme of having their children removed and placed into care. These are sometimes women who have actually asked for help regarding their parenting because of difficulties stemming from their childhood. Instead of receiving any support, they are investigated and pursued as child abusers themselves. Professionals seem to perpetuate myths and stereotypes around child abusers and around victims of child abuse.

6. Many of the Social Workers involved in interventions with mothers who are survivors of childhood abuse appear to have no understanding at all of the trauma of sexual violence, especially for a child. They seem to find it impossible to look beyond the woman’s childhood history and see all the things she has managed to do in order to survive and raise her children. This makes it very difficult for them to notice and acknowledge the changes which a mother does make when support is provided, as they constantly look to the past.

7. An “investigation” into abuse following a disclosure sometimes consists of asking the alleged abusers if what the child says is true. As they don’t say yes very often, children are often left at risk of more extreme abuse because of having told. When I supported a teenager to disclose the sexual abuse perpetrated by both her parents, the police officer kept asking her why she wasn’t going to go home! There was no statutory support for her to be moved somewhere safe, that was left to the voluntary sector to undertake. Although she gave hours of evidence and a very detailed statement, her parents were spoken to only briefly by the police and no notice was taken of my request that they look at the computers in the house as the daughter was aware of child pornography on them. Meaningful joined up working might have led to a very different outcome for the girl, and for her brother who was left at home with no support, and for the children her father coaches for football.

8. There are no effective guidelines for schools around supporting victims of child abuse, and this is especially a problem when there is sexual violence between peers at the school. We have worked with several cases where a young woman and the young men accused of assaulting her are at the same school, and they must deal with each other on a daily basis while investigations take place, and in some cases during and after a court case. This difficult situation is sometimes exacerbated by insensitive staff members or punitive policies. In one case the victim was given the responsibility of walking away from the boys who assaulted her if she
saw them in school—this meant that she couldn’t use the library, for example, if she saw them in there. In the end, this girl could not cope with school anymore, and went without education for several months while her mother tried to get her accepted into another school. Thus, she was revictimised by a system which should have been supporting and protecting her.

9. The way that child protection legislation and guidelines are implemented very often silences children. In many organisations, including schools, it is common for a member of staff to say to a child who is trying to talk to them something along the lines of “If you carry on telling me this, I will have to involve someone else.” Children work out from an early age that telling someone will lead to something which is out of their control, and therefore they don’t tell. This is exactly the kind of thing which the legislation was trying to avoid, but the way it is implemented makes it more not less difficult for many children to disclose—this is one of the reasons why Rape Crisis Centres do so much work with adult survivors. They may have tried to tell as a child, sometimes even more than once, and then given up and waited until they were older. Obviously, the support and therapy they need as an adult tends to be longer term and more difficult than if they had been able to access help when they need it. Early intervention and early help is much more effective.

10. There are always going to be cases of parents/carers/family members abusing children which cannot be proven due to lack of evidence. However, it is dangerous to simply close these cases with no provision of support. Not only is the child sometimes punished for the intervention which has occurred, but there is no monitoring, no follow up and no support for the child—or for other members of the family, once a case is closed. Although police officers and social workers seem to be aware of this, there seems to be no provision for making a referral for support for the child and the family, where appropriate. This means that the abuse simply continues, often worse than before. The referral of the child for support, and follow up contact, might ameliorate the risk of this.

11. Statutory workers are still “taken in” by the charming and the well presented. Despite all the evidence and understanding around appearance, their training does not seem to prepare professionals for looking beyond the surface. Once again myths and stereotypes.

12. Even very violent and abusive men are given access to their children in unsupervised contact following divorce. The Family Courts often make contact orders which put vulnerable mothers and children at the mercy of ex partners who are then free to continue to control, influence and disrupt their lives.

13. Women and girls have consistently said over the last three decades that they prefer to be supported by women only organisations, and yet many vulnerable children and women are neither referred to women only organisations nor given information about their options.

14. Statistics around childhood sexual abuse are consistently hidden in many local authorities as they become subsumed in the “neglect” category in Social Care statistics or the “no crime” category in police statistics. This means that there is no true record of prevalence, and statutory authorities are not paying attention to victims of sexual violence.

15. Dedicated specialist services have consistently demonstrated that the support they provide to victims of sexual violence is more effective than that from Statutory services.

RECOMMENDATIONS FOR ACTION

— That, even when a statutory investigation into child abuse is closed with No Further Action, a referral should be made for the child and non abusing parents/carers to a specialist support service, such as a Rape Crisis Centre.

— That, when there is statutory intervention regarding the wellbeing of a child or children of a childhood abuse survivor, referral of the mother for therapeutic and practical support is made to a specialist service early on in the process, with attention being paid to the positive changes which stem from the support as part of the statutory monitoring of the case.

— That all Social Workers involved with child protection cases should undergo specialist training on sexual violence so that they understand the power and control dynamics exercised by abusers, and so that they gain an understanding of trauma and trauma responses. At the very least, training to unpick and challenge myths and stereotypes about abusers and the victims of child abuse needs to be provided.

— That there be more practical and effective guidelines for schools on how to best support victims of sexual violence within the school setting.

— That there be consultation on how to implement child protection policies without silencing children who have been or are being abused.

— That statutory bodies should be encouraged to recognise the expertise and the knowledge within the voluntary sector, and to take information provided by them seriously.

— That Family Court staff receive better training in child protection issues so that their orders protect children and vulnerable mothers from continued involvement with violent and abusive men.

— Women and girls have need to be given the option of women only services.
— Statutory services should maintain more accurate statistics about the prevalence of childhood sexual abuse in particular.
— Specialist sexual violence services should receive more recognition for the contribution they make to the well-being of victims of sexual violence, and victims should be enabled to access such services as a matter of course.

November 2011

Written evidence submitted by Beatbullying

BACKGROUND

1. Beatbullying is the UK’s leading bullying prevention charity, creating a world where bullying, violence and harassment are unacceptable. Beatbullying empowers people to understand, recognise and say no to bullying, violence and harassment by giving them the tools to transform their lives and the lives of their peers. We work with families, schools and communities to understand the problem, campaign for change and provide sustainable, efficient and proven solutions.

2. One of the main ways in which we do this is by training CyberMentors (www.cybermentors.org.uk). CyberMentors are young people who are trained to mentor—both on and offline—other young people who are being bullied or have problems related to their wellbeing. CyberMentors are trained to refer high level issues to BACP-accredited counsellors, if the severity of the issue makes that necessary. We have found this online model of service provision a particular success in helping children overcome the difficulties they encounter and a particular success in helping to safeguard and protect vulnerable children.

3. Beatbullying has developed a range of mentoring programmes designed to reduce and prevent the incidence of bullying. These programmes involve intense training in mentoring and creative activism. Our programmes have been fully evaluated and peer reviewed by academic organisations and institutions such as the University of Sussex, Goldsmiths University of London, New Philanthropy Capital (NPC), and the Centre for Excellence and Outcomes for Children’s and Young People’s Services (C4EO). Our flagship CyberMentors programme has recently been awarded as an example of “fully validated” practice under the C4EO early intervention theme.

GENERAL COMMENTS

4. Beatbullying welcomes the opportunity to respond to the Education Select Committees inquiry: “New Inquiry: The child protection system in England”.

5. Our work has gained significant recognition since its launch in 2002. This response is based on knowledge, research and evaluation gained through providing a programme of work and support to schools, local authorities, and communities.

6. Beatbullying also has a dedicated Child Protection and Safeguarding Team responsible for ensuring that all policy, protocol and procedure is effectively implemented throughout all the work that the charity does, and ensure the welfare and safety of all the young people that it works with.

SPECIFIC COMMENTS

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

7. Services targeted at children and young people should be more engaging in order to encourage those in need or at a high level of risk access it. Services such as www.cybermentors.org.uk offer a unique and innovative example of how we should engage and protect children. It provides an approachable and engaging online service for children and young people aged from 11–17 who are in need of help around wellbeing issues, particularly around bullying. This type of support is delivered in a medium in which children and young people identify with and are comfortable in using. CyberMentors has been endorsed and “fully validated” as an example of effective early intervention by the Centre for Excellence and Outcomes for Children and Young People’s Services (C4EO), and cited with the Graham Allen Review on Early Intervention, and several other Government Reviews, including the Brian Lamb Review on SEN and disability.

8. Through this service, the children and young people who visit the site have access to trained peer mentors, who, in response to anything that is regarded as a sensitive or child protection issue, can refer them on to a BACP-accredited counsellor who is able to gauge the amount of risk the child or young person is in and offer the appropriate level of support via contracted counselling sessions (where appropriate). It follows, where there is a high level of risk or a serious disclosure of a safeguarding nature, the incident is referred to Beatbullying’s Child Protection and Safeguarding Team who co-ordinate action within the organisation and liaise with external health, emergency and children’s services where relevant.
9. The site also offers a several ways for a child or young person to access support, allowing immediate and real-time intervention. In terms of safeguarding cases, since 2011, 46 safeguarding cases have been recorded on the CyberMentors platforms (July 2011), half of which (50.0%) have resulted in external referrals to external agencies (2.2% CEOP, 19.6% Police & Emergency Services, 28.3% Social Services). As a result of this experience, this model has proved to be successful at identifying those in serious risk and referring them efficiently on to external agencies. As one of our users was quoted as saying “it’s been a life changing experience and very positive and life saving”.

10. In addition, we would suggest that the children and young people themselves need opportunities to voice their opinions on how effective the child protection system is, as we have found in our own work, services for children and young people work best when children and young people are consulted and informed.

Factors affecting the quality of decision-making in referral and assessment, and variations across the country

11. An improvement in this area would be for clear, standardised and enforced guidelines to be enforced about information sharing so that reported risk factors can be collated and risks identified earlier. This would make it easier to trace and track referred cases.

12. Consideration should be given to online services liaising with offline services to create ease in referral and a joined up approach to assessment. For the moment, the thresholds for providing a child in need of support vary, which results in disjointed support.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

13. There should be appropriate and accessible support services for the families as a whole. We know that evidence suggests it is better for families to be kept together where possible. Therefore, more work should be conducted on early intervention to prevent issues from escalating to the point where a child may need to be removed from their family. In many cases, where families receive early support, they usually remedy any problems they may have been experiencing, allowing the child to once again be safe with their family, where they are arguably best placed. Removing a child from their family is a distressing, time-consuming and costly process and should be seen as a last resort. With more accessible early intervention, this should become a less necessary option. Such intervention therefore needs to be accessible and appropriate to families.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

14. The crucial role of statutory and non-statutory children’s services in assisting professional bodies protecting and safeguarding children should not be underestimated. The policies and practice of these organisations should, of course, be consistent (where relevant) with social work and Government departments to ensure the ease of multi-agency working. We therefore believe more money should be invested in national safeguarding and child protection, embracing national and universal methods of communication and methods of protection to make this happen. There should also be consistent standards across on and offline provision.

November 2011

Written evidence submitted by Association of Directors of Children’s Services (ADCS)

1. INTRODUCTION

1.1 ADCS is the national leadership organisation in England for directors of children’s services appointed under the provisions of the Children Act 2004 and for other children’s services professionals in leadership roles. The statutory role of director of children’s services (DCS) was created by the Children Act 2004 to establish a single point of leadership and accountability for services for children and young people.

1.2 We are grateful for the Committee’s consideration of this submission and particularly of the following key points around which our evidence is based:

— The challenge posed by increasing numbers of referrals to social care and of children with looked after status, at a time of diminishing resources.
— The efficacy of the child protection system depends on robust multi-agency working, but the scale of change in both the health and education systems present significant risk in the transition. New inspection frameworks must underscore the role of all partners in child protection and safeguarding.
— Data sharing is also crucial but there are still significant barriers to sharing information, particularly with colleagues in health services.
— Local authorities are unsgrily committed to improving standards of the children’s workforce through implementation of Social Work Reform Board and Professor Munro’s recommendations.
2. Identification and Early Help of Children at Risk

2.1 Referrals to social care continue to rise. Latest Department for Education (DfE) figures show 6,000 more referrals in 2010–11 than in 2009–10, an 11% rise in referrals since 2004–05, a 34% increase in initial assessments from 293,000 to 441,000 and a 63% increase in children with child protection plans from 25,900 to 42,300 over the same period. Overall, numbers of looked after children are rising too—there are currently 65,520 children who are looked after, a rise of 9% since 2007. These figures show the ever increasing pressure being faced by children’s social care services in local authorities. Cafcass figures for the end of July 2011 show that in the period April to July 2011 there were 3,213 new public law applications. In the same period in 2008/09 there were 1,633. This is an increase of 97% in applications. The rise in care proceedings and the number of those proceedings resulting in children coming into care suggests that these children are in very real need of protection, and that the increase reflects previously unmet need, rather than a change in the thresholds for accepting a child onto the children’s social care caseload.

2.2 We know that providing early help can reduce the need for child protection interventions that are more complex and more expensive. The identification of children who are vulnerable or at risk and the provision of early help to them and their families requires effective multi-agency working. Many local authorities already have multi-agency teams located in community services where professionals from early years, health and education services can discuss child protection concerns and potential referrals. A mutual understanding of child protection across the many professionals that should contribute to the referral and assessment of children is crucial to the efficacy of the system. There are often tensions between professionals and we believe inter-disciplinary inductions and opportunities for shared learning are an effective way to foster co-operation and secure the necessary awareness of individuals’ roles in the system.

2.3 We support the principle of Professor Munro’s recommendation for a duty to secure the sufficient provision of local early help services for children, young people and families. It is right that local authorities should be the lead agency in securing sufficient provision but the duty must be binding on all partners and framed in such a way that it empowers local authorities to secure contribution from others. It is important to conceive of this duty to provide early help as incorporating early help (ie preventative interventions) to parents who have drug, alcohol or mental health problems too as a means addressing the causes of child neglect and thereby hopefully reducing demand further down the line for high end child protection services. We are concerned that the Government only accepted this recommendation in principle.

2.4 We are concerned that, although schools continue to be subject to a duty to ensure the safety and wellbeing of children and young people, safeguarding in schools appears to have been downgraded in the revised inspection framework. Local authorities will need to work with schools, both academies and maintained, to support access to social work expertise and strong referral and feedback processes for vulnerable children. It is also essential that schools continue to play their role in the provision of early help for vulnerable children and young people and those who are at risk of harm.

2.5 We remain concerned that the difficult fiscal climate continues to present an enormous challenge to meeting the aspiration for early intervention, at a time when it is needed most. Although most local authorities have protected child protection services from budget cuts, and some have increased them, the surge in demand has lead to many statutory child protection services being further stretched. The challenge to the system therefore is to safely reduce demand for statutory child protection services. Raising thresholds is one way of doing this this, but is too risky for most local authorities to consider. Therefore, local authorities and their partner agencies (including health, police, schools) must focus on prevention (in this case meaning reducing the number of those proceedings resulting in children coming into care) as a means of reducing demand. This can only be achieved through effective multi-agency working and co-operation.

2.6 The next settlement of the Early Intervention Grant, including the proportion that is to be subject to payment by results, remains to be formulated. The level of funds and configuration of the settlement will clearly impact on the capacity of local authorities to effectively design and resource services. The overall pressure on all public sector budgets for children’s services whether in local authorities, the police service, the NHS or education and learning services will have an impact on the capacity to safeguard children and ensure all agencies can work together effectively to protect children and young people.

92 DfE (2011) “Referrals, assessments and children who were the subject of a child protection plan” (2010–11 Children in Need census, Provisional) http://dfedu.uk/researchandstatistics/statistics/recentreleases/a00196856dfereferencesassessments-and-children-who-ware-than
3. FACTORS AFFECTING THE QUALITY OF DECISION MAKING IN REFERRAL AND ASSESSMENT, AND VARIATIONS ACROSS THE COUNTRY

3.1 We welcomed the acknowledgment in Professor Munro’s final report that risk cannot be removed from the system.95

3.2 Central to the quality of decision making in referral and assessment is the workload of individual social work practitioners and their immediate managers. Where caseloads are lower there is a much greater chance that staff have the time to listen and respond to the needs of individual children and families, to reflect on what they have seen and heard, to liaise effectively with partner agencies and to devote time to their professional learning and development. One of the features of services that have been judged inadequate or have had priority actions following unannounced inspections of referral and assessment services has been high caseloads. The problems in managing the work are usually not solely about volume of work in relation to capacity of the staff but it is a critical component of poorer performance.

3.3 We acknowledge that although many elements of good practice have been identified, on-going reform of the social work profession is welcome and necessary in order to improve the quality of new entrants to the profession and boost the professional confidence and expertise of the existing workforce. Local authorities are unswervingly committed to improving standards of the children’s workforce and through that securing better outcomes for vulnerable children and young people. A comprehensive overhaul of expectations, training, accreditation, career structures and professional bodies is underway, underpinned by ambitions set out by the Social Work Task Force. ADCS is working closely with government and our partners to shape and implement reform.

3.4 We are committed to contributing to the implementation of Professor Munro’s recommendations to establish a culture of learning, rather than blame, an environment supportive of professional judgement rather than prescriptive guidance and sufficient investment in the long term development of social work and social workers to build a strong and confident workforce that is well trained and well supported.

3.5 Driven by the Children’s Improvement Board, a framework for sector-led improvement and support has been established. The framework seeks to establish a robust system of diagnosis and improvement to raise the performance of every area of children’s services in every local authority, whether a strong or weaker performing authority. The system will work alongside external inspection regimes and, although tailored to meet the requirements of each authority, key elements include: self assessment; peer challenge; self reflection; and the sharing of good practice between local authorities, to the benefit of both target and peer reviewing local authorities.

4. APPROPRIATE THRESHOLDS FOR INTERVENTION, INCLUDING ARGUMENTS FOR AND AGAINST REMOVING CHILDREN FROM THEIR FAMILIES

4.1 We know that the outcomes for children removed early in their lives from their families because of the serious harm they have suffered or are likely to suffer and placed with permanent substitute carers (whether within the wider family or through stranger adoption) are better. There is a growing body of evidence about the lifetime impact of poor care in infancy and of the poor outcomes for children who have suffered serious harm and are returned to parents where there has not been transformational change in the quality of the parents’ care.

4.2 ADCS would support a wider debate on these very difficult issues about the purpose of “public care”, when and how the state should intervene in families’ lives, and when it is right to permanently remove children from their parents’ care and place children for adoption with the severance of the legal ties between birth parents and their children this entails.

4.3 In the context of rising numbers of looked after children and decreasing resources, local authorities will be applying for more adoption orders in the last year in order to achieve this. This may not be reflected in the figures for the number of adoption orders this year due to the delays within the court system meaning that such decisions can take well over a year to be made.

4.4 The Association strongly believes that long term decisions regarding the care of vulnerable children must emerge over time and be flexible to changing circumstances. Rarely are child protection cases clear cut and predictable with absolute certainty. The current system is set up to deal with “knowns” but care proceedings must also be able to deal with “unknowns”, such as whether a parent will significantly improve their parenting after undertaking treatment for drug addiction for example.

4.5 We support the full implementation of recommendations in the interim report of the Family Justice Review (FJR)96 which we believe will help to deconstruct the adversarial nature of public law which is not well suited to cases before family courts, particularly as in the majority of cases there is no dispute on harm or cause of harm. It proposes a desperately needed rationalisation of current structures and processes alongside


workforce reforms to achieve increased leadership capacity and clarity of roles and responsibilities of different organisations and individuals involved.

4.6 We particularly welcome the proposal to refocus the work of the courts on the fundamental question of whether a care order is in the child’s best interest and less on the local authority care plan. We also believe the proposed changes to the role of Cafcass and children’s guardians are important as we are confident that this resource will be better used if targeted on the more complex cases and subject to strong judicial case management. The guardian role should not be to re-assess cases, but to validate and challenge the local authority plan as appropriate, from the perspective of the child’s best interests. Local authority social workers’ care plans and assessments need to be sufficiently robust to face this challenge, or to accommodate alternative possibilities.

5. CHILD PROTECTION POLICIES AND PRACTICES OF NON-SOCIAL WORK AGENCIES AND GOVERNMENT DEPARTMENTS ASSIST PROFESSIONALS TO WORK TOGETHER IN THE INTERESTS OF THE CHILD

5.1 Multi agency working and public service reform

5.1.1 The importance of strong multi-agency working to effective child protection regimes cannot be overstated. The scale of flux in public services, particularly in the health and education systems, presents huge challenges. It is essential that child protection remains a central consideration of the health and education reforms.

5.1.2 This holistic approach to child protection needs to work horizontally and vertically across agencies. Horizontal integration across agencies who work with children is important in establishing a safety net to identify vulnerable and at risk children and young people and mitigate the harm done to them. However, vertical integration between children’s services and the services of partner agencies working with adults is vital to achieve effective prevention of harm to children, because it involves changing the behaviour of the adults in their family that is putting them at risk. In this way it is attacking the causes of harm (ie adult behaviour) as well trying to limit the effect of that harm on children. This is not an argument for vertical integration between local authority children and adult services departments, although that can be helpful. Rather, it is the services provided by police, probation and health agencies that work with adults to change their behaviour that will make the most difference to the risk of harm to children. This means a joined up approach with, for example, adult drug, alcohol, offender and mental health services, because changing adults’ behaviour to make it less harmful to their children is the best way to prevent or reduce demand for child protection services. This may involve changes in the way thresholds for adults receiving a service are applied in those services, to prioritise those adults with children who they may be putting at risk. For example, in many areas adults with mental health difficulties which may put their children at risk of neglect or harm often do not meet the threshold for mental health services, because it is only the needs of the adult concerned which are assessed by commissioners.

5.1.3 We are concerned that the scale of public service reform in services key to the child protection system presents huge challenges to the robust multi-agency working outlined above.

5.1.4 In the current health service reforms, while accepting that there are proposals to transfer safeguarding responsibilities currently held by PCTs and SHAs to the new health infrastructure, we are concerned that these responsibilities may become diluted and/or fragmented across the range of new structures and systems delivering health care. The governance relationships between LSCBs and Health and Wellbeing Boards will be crucial to hold health professionals, including clinical commissioning consortia to account, but these still remain unclear. In a recent survey of LSCB chairs, we found a 22.5% increase in vacancy rates for safeguarding nurses and a 65% vacancy rate for designated looked after children leads since 2010.

5.1.5 We are concerned that child protection and safeguarding may be compromised by a potentially inadequate representation of the needs of children and young people in the planning and commissioning arrangements in the proposed system. For example, there is only one “children services’ representative on the Health and Wellbeing Boards (Director of Children Services). We would expect that in any new arrangements, all partners are cognisant of their wider roles regarding safeguarding and child protection and to see this as part of their core responsibilities. We are concerned that a fragmented approach in national policy, particularly between government departments towards responsibility for children and family services may resulting in differences in approach, for example “individualism” in the Department of Health and “families” in the Department of Education.

5.1.6 With increasing provider diversity and autonomy in the school system we are concerned about continuing to secure the close co-operation of all schools in the local child protection and safeguarding system, including in identification of children and risk and the provision of early help. Local authorities have a clear role in supporting schools, maintained and academies, in fulfilling their safeguarding and child protection duties, for example through provision of training and continuing professional development for safeguarding leads and support in identifying and commissioning evidence based early help services. It is currently unclear where responsibility for such provision in terms of accountability and resources sits, particularly regarding

97 ADCS survey of independent LSCB Chairs, October 2011.
academies. We believe these responsibilities should be considered as part of the identification of roles and responsibilities related to the funding formula for schools and local authorities.

5.2 Data sharing

5.2.1 We remain concerned about persistent barriers to data sharing, particularly with colleagues in the health sector. In the absence of Contact Point, further work must be done to facilitate the effective sharing of data between health professionals, including health visitors, and children’s centres to enable accurate identification of need and targeting of services.

5.2.2 Some local authorities recently adopted the National eCAF (NeCAF) system for the Common Assessment Framework (CAF) and reported that it provides a strong model for integrated and cross-border working as well as ensuring information can be shared consistently across the country—it is essential to know when and where some families move, and that children are receiving the appropriate support.

5.2.3 We are concerned that the future of the NeCAF is now uncertain. The adoption of NeCAF has been at considerable cost to local authorities, financially and in terms of good will of partners, children young people and families. Further changes will mean local authorities incurring yet further cost and risking in many cases recently strengthened trust and co-operation.

5.3 Statutory guidance

5.3.1 We welcome government’s decision to revise the statutory guidance Working Together and are pleased to contribute to the working group leading the drafting of revisions. Working Together cannot be seen in isolation. It is crucial that statutory and non-statutory guidance in the entire process be considered in the same way and at the same time, including guidance on care planning and reviewing processes for looked after children, fostering and adoption. The Children Act 1989 should remain the starting point for revisions of the full suite of guidance.

5.4 Inspection

5.4.1 Consultation has recently closed on proposals for reformed inspection of local authority children’s services (safeguarding and looked after children). Given the role of other agencies in determining the child’s journey through local authority safeguarding services, it is crucial that the inspection framework, judgements and final report include consideration of the contributions of other agencies. While we acknowledge that the director of children services has the overall accountability for the strength of partnerships and multi-agency working, inspection judgements should be clear about the contribution of other partners to the inspection outcome—in particular in judgements about leadership and management and overall effectiveness of the help provided.

5.4.2 We particularly welcomed the proposal to observe multi-agency meetings such as case conferences and to examine the role of other agencies in early help and in referral processes. This should include Team around the Child/CAF meetings to decide on early help services offered. Similarly we welcome the commitment for the inspection team to include HMIs from both education and social care backgrounds in recognition of the role of schools and local authority education functions to safeguarding efforts.

5.4.3 We remain concerned at the lack of progress in ensuring that other inspectorates are involved in the development of the framework or delivering the inspections. We appreciate the difficulties in this area given changes to the regulatory and inspection framework in health but feel strongly that co-ordinated inspections offer an effective means of judging multi-agency approaches to services for children.

November 2011

Written evidence submitted by the ACPO lead for Child Protection and Abuse Investigation

EXECUTIVE SUMMARY

1. Challenges do exist within the child protection system in England. Specific issues for the police service include the level of referrals in child protection cases, budgetary constraints and different approaches to the provision of child protective services.

2. There is a need to continue to provide a coordinated approach across the police community. Whilst the process may differ between police forces, ACPO aims to provide consistency through the provision of national guidance on standards, policy and procedure.

3. There is a need for all professionals who come into contact with children to understand significant areas of risk for children and young people and to be able to identify risks factors at the earliest opportunity.

4. ACPO acknowledges that there is an ongoing need to develop the ‘tool kit’ available for frontline police officers, including a risk assessment model to identify risk of harm to children.
5. There is a need to develop a more coordinated response to child protection by organisations involved in the safeguarding and protection of children.

6. This submission will respond to questions 2, 3, and 4 of the Education Committee’s inquiry.

INTRODUCTION TO ACPO

7. The Association of Chief Police Officers (ACPO) is the professional voice of the police service of England, Wales and Northern Ireland. ACPO brings together the expertise and experience of chief police officers, providing a professional forum to share ideas and best practice, coordinate resources and help deliver effective policing which keeps the public safe.

8. An independent, strategic body, ACPO acts in the public interest as an active partner to government, leading and co-ordinating the direction of the police service. ACPO comprises chief officers who hold a substantive rank or appointment at Assistant Chief Constable Level, Commander and police service staff equivalent. Collectively, over 300 leading police executives provide a critical and an informed understanding of the complexity of policing at local, regional and national levels.

9. Peter Davies is the ACPO Lead for Child Protection and Abuse Investigations (CPAI), which sits within the ACPO Violence and Public Protection Portfolio. In addition, Peter Davies is the Chief Executive Officer of the Child Exploitation and Online Protection (CEOP) Centre. CEOP has responded with a separate submission focusing on question 1 of the Education Committee’s inquiry.

10. The aim is to provide a submission from the ACPO Lead for CPAI.

SUBMISSION

Question 2—What are the factors affecting the quality of decision-making in referral and assessment, and variations across the country?

Variations in Police Approach

11. The priorities of the police service in relation to child abuse are to:
   — protect children and ensure that the welfare of the child is paramount;
   — investigate all reports of child abuse and neglect;
   — protect the rights of child victims of crime;
   — bring offenders to account; and
   — adopt a proactive multi-agency approach to preventing and reducing child abuse and neglect, as well as safeguarding children.


12. It is for each Chief Constable to determine how these statutory obligations are being fulfilled and by implementing local policies and procedures to ensure that the police response achieves these priorities.

13. In times of austerity where police budgets are being cut, there is a drive to reduce bureaucracy and to improve the efficiency and effectiveness of police resources to ensure high standards of services provided to the public are maintained. ACPO recognises the importance of adequate resourcing for child protection teams.

14. Child protection arrangements across 44ACPO Home Office Forces include England, Wales and Northern Ireland. forces vary in format and include Child Abuse Investigation Teams (CAITs), Child Abuse Investigation Units (CAIUs) and Public Protection Units (PPUs), amongst others. Differences in the size of police forces and their child protection teams, resourcing issues and structure may also lead to different approaches to dealing with the variety of child abuse cases that are investigated, including arrangements outside the specialist child protection teams.

15. Such differences in local practice in resilience and resources within local forces and between different agencies will impact on decision making in referral and assessment.

Early and Effective Identification and Assessment of Risk

16. The early identification of risk of harm by all those, whose work brings them into contact with children, is an important factor in the prevention, detection and mitigation of harm occurring to children and young people. Early identification is enhanced by improving the awareness for professionals of what the risk indicators are, as well as through the provision of education to children, their parents and carers on risk and safety. The development and implementation of child protection policies, training and effective reporting mechanisms are all key factors to ensuring that issues are raised at the earliest opportunity.

17. Once risk has been identified, it is the role of the experts, including Children’s Services and the Police to make an assessment of the level or risk and determine if any safeguarding measures are required.

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98 ACPO Home Office Forces include England, Wales and Northern Ireland.
18. A variety of risk assessment models are used across police forces in England, Wales and Northern Ireland. For example, the Child Risk Assessment Matrix (CRAM) has been developed and is used by the Metropolitan Police Service and has also been adopted by a number of other forces. The CRAM is a risk assessment process that uses intelligence research as the basis for making decisions concerning the welfare of vulnerable children. The CRAM relies on the collation of relevant information from police records and partner agencies to regularly evaluate risk to children to identify missing information.

19. Barnardo's developed a model called the Domestic Violence Risk Identification Matrix (DVRIM)\(^9\) that is a multi-agency assessment tool in assessing the level of risk to children who experience domestic violence. This is currently being used within West Midlands police forces. A number of forces, including Nottinghamshire, Kent, Cumbria and Kent have developed their own specific risk assessment referral process.

20. Currently there is no universal risk assessment process in place for agencies that provide protective services for children.

21. ACPO believes there is a need to review current models operating in forces and to develop an effective common national evidence-based risk assessment model for child protection to assist forces and partner agencies in their assessment in child abuse cases. It is also important to ensure that the development of a national model will fit with the wider multi-agency risk assessment models and statutory guidance, and is transferable across partner agencies. ACPO believes it is important that the risk assessment process covers emerging risks and issues such as the recording of minor incidents in order to identify the potential and escalation or risk.

Information Sharing

22. The different ways that police forces deal with child protection cases, together with the variety of ICT systems in use, means that there is no standard structure or definitions in place for the recording of information on child abuse. This impacts on the ability to collate data and compare information on a national basis.

23. There is a need for a common framework set of definitions for all agencies to record information on all forms of abuse. For example, cases of online abuse should be recorded In the same way as those of intra-familial abuse, to give an enhanced picture of the scale of the issues. As such, non-traditional forms of abuse, such as online grooming, child trafficking, forced marriages or female genital mutilation (FGM) would be appropriately recorded and easily retrievable for analysis. Ideally it should be possible to determine the number of victims who are children and their ages in any area.

24. Whilst there is currently no common ICT infrastructure across forces, the development of the Police National Database (PND) will offer the police service the ability to share and access information held on local systems across all police force borders.

25. There is a need for government to continue to support the development of the PND to increase the range of services it can provide and ACPO are encouraging forces to migrate all relevant information related to child protection across to the PND. This will enable forces to make more informed decisions and better risk assessments.

26. The PND will be utilised to track serial perpetrators or persons of interest across borders; this will assist forces in the local management of those who pose a danger to children and families.

27. Information sharing between partner agencies has a significant impact on decision making. Professionals making a judgment in relation to risk of harm to children can only base decisions on the information they have available at any particular time. Therefore it is imperative to work towards developing improved working practices between education, health, social care, the police service and other relevant agencies in relation to information sharing. If necessary, organisations should review and revise information sharing protocols and work together to overcome any barriers that may exist to sharing information in relation to the protection of children.

28. ACPO supports the development of sharing learning and good practice including developing information sharing protocols across all agencies.

Question 3—What are the appropriate thresholds for intervention, including arguments for and against removing children from their families?

29. Children’s Services have a statutory duty under Section 47 Children Act 1989; to make any enquiries where there is a reasonable cause to believe a child has suffered or is likely to suffer significant harm. The responsibility for this lies with the Local Authority where the child lives or was found.

30. Police forces have a responsibility to investigate crimes in relation to child abuse. Police will refer children to Children’s Services in circumstances where they have reasonable cause to believe a child has suffered or is likely to suffer significant harm. In undertaking enquiries, to decide if any action is necessary to safeguard a child, Children’s Services will work closely with the police. Local arrangements will vary but

guidance (referred to in para.34) refers to working closely and developing good communication between different agencies in the best interests of the child.

31. Police, as well as Children’s Services, also have powers under section 44(4) Children Act 1989 to remove a child from a location or prevent removal from hospital or other place in circumstances where there is a risk to a child’s life or the possibility of immediate harm.

32. The threshold for intervention is where there is reasonable cause to believe that a child is at risk of harm or likely to suffer any harm. In making an assessment of whether this threshold has been met, variations will occur. The challenge is addressing these variables to ensure that cases are only referred when the appropriate threshold has been met.

33. Forces are integrating into LSCBs to work together with the relevant agencies to determine whether the appropriate threshold has been met and to make decisions if any action is needed to safeguard a child.

Question 4—Do the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child?

Policy and Procedure

34. ACPO develops national policy guidance and practice advice that informs policy and procedure at a local level. Examples include the Guidance on Investigating Child Abuse and Safeguarding Children. The guidance focuses on general issues on the investigation of child abuse (Part 1) and the investigation of complex abuse (Part 2). Broader issues on safeguarding children are covered in Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. The overarching principle is the welfare of the child and the guidance focuses on the provision of a consistent police response and quality of investigation irrespective of the type of abuse or the environment within which the abuse took place. Further specific guidance on domestic violence and rape will also inform force policy in relation to child abuse.

35. In October 2009, the Home Office National Police Protective Services Board (NPPSB) commissioned ACPO to produce a delivery plan. The Board asked ACPO to focus on the police contribution to child protection and to consider where practice was weak and suggest improvements tackle this on a national, regional and local level. The plan was a key component in the government’s response to Lord Laming’s progress report following the death of Baby Peter.

36. ACPO CPAI developed the Child Protection Delivery Plan (CPDP) following a period of consultation and produced an action plan that cut across a whole range of child protection issues, and attempted to provide synergy between programmes of work ongoing in other agencies including the National Policing Improvement Agency (NPIA), Her Majesty’s Inspectorate of Constabulary (HMIC) and the Home Office. The CPDP addressed matters that included communication, resourcing arrangements for force CAIUs, the provision of specialist resource, risk assessment processes, joint agency working and training. This plan has driven the work of ACPO CPAI.

37. In developing its policy and procedures, ACPO supports Munro’s view of placing greater emphasis on the importance of professional practice and judgment in relation to child protection. Munro spoke of the “blame culture” that has developed in relation to child protection. ACPO supports this view.

Multi Agency Approach

38. There has been a drive across ACPO towards the multi agency approach when dealing with all matters concerning child protection. ACPO is working closely with partner agencies to identify opportunities where integrated services or co-location will benefit from the provision of child protection services.

39. An example includes the development of Multi Agency Safeguarding Hubs (MASH). MASH’s bring together a variety of agencies that include children’s services, education, police and may include the National Health Service. Some forces that are developing work in this area include Devon and Cornwall and Avon and Somerset. The Metropolitan Police Service is currently setting up a number of pilots due to commence in the near future.

40. The development of MASH’s, with key agencies embedded and working in close collaboration, will have a positive impact on improving the knowledge available when making any risk assessment.

41. A further example is the ongoing work ACPO is engaged in, with the Children and Family Court Advisory and Support Service (Cafcass) and Cafcass Cymru in private law cases. Police officers are embedded in Cafcass’s national business centre to ensure the family courts receive relevant information in a timelier manner with greater efficiency and effectiveness. This provides a greater service to vulnerable
children, having removed the administrative burden from local forces and allowing forces to focus on providing frontline policing services.

42. ACPO is working on a number of initiatives to improve services provided around missing children, including working closely with the Home Office in relation to the missing person’s strategy that is due for publication in the near future. The development of these services for missing children is focused on the close working relationships of all sectors who work to locate and protect children who go missing, including non-government agencies and those within the charities sector.

Training

43. ACPO is working with the NPIA to develop an enhanced learning programme with a range of standard and specialised courses that aims to ensure consistency in the provision of training on a national level to police officers. Within the training programme, there has been a drive to introduce and develop inter-agency training that aims to bring together experts in particular fields with the aim or working more closely together in the best interests of the child.

44. The Specialist Child Abuse Investigation Development Programme (SCAIDP), a training programme for officers working within the child protection arena, now includes inter-agency training. An example includes police forces inviting social care to take part in training on interviewing children or young people in relation to achieving best evidence (ABE). In addition, a number of specialist interest seminars have been developed covering topics that include investigating complex child abuse cases and near misses are aimed at police officers at all levels, social care, education and health.

45. ACPO CPAI and NPIA are also working with LSCB’s and NSPCC in conjunction with social care, health and education, to develop a bespoke child protection multi agency critical incident training course. The aim is that this training will be led by LSCB’s and provide training across all agencies. Work is progressing and the intention is to run a number of courses as a pilot in 2012.

Conclusions

46. The early identification of risk and ability to make effective assessments is important for all professionals who have a duty to safeguard children with a coordinated process for dealing with referrals.

47. There is a need to continue to develop a coordinated approach across all child protection organisations in respect of policy development, training and in the utilisation of specialist services in the investigation and prosecution of offenders and after care required for victims and their families.

48. A multi agency approach within the child protection system should be supported with all agencies working together to share expertise, knowledge and overcome any barriers to sharing information.

November 2011

Written evidence submitted by the Child Exploitation and Online Protection Centre

EXECUTIVE SUMMARY

1. The Child Exploitation and Online Protection Centre has developed specialist knowledge and expertise relating to the sexual abuse and exploitation of children and young people. In our view there are a number of issues which need addressing in relation to the new manifestations of sexual abuse and exploitation and the challenges these create for professionals.

2. There is a need to develop the understanding of frontline professionals around these areas of work, to improve the tools that they use, and to identify areas where they need greater support such as in the identification and assessment of risk.

3. There are without doubt considerable challenges facing the English child protection system in fully understanding significant areas of risk, including behaviours in the online environment.

4. Challenges also exist in terms of the system being adequately resourced and equipped to respond to the exploitation of older teenagers, and the cross-over between different areas of risk being fully understood.

5. CEOP’s submission, therefore, will address the following issues:
   — The changing nature of sexual abuse.
   — The professional response.
   — The need to understand children’s risk taking in the online environment.
   — The need to understand the seriousness of non-contact sexual abuse.
   — Risk assessments and guidance.
   — Trafficking and sexual exploitation.
   — Prevalence.
INTRODUCTION TO CEOP

6. The Child Exploitation and Online Protection (CEOP) Centre is the UK’s national law enforcement agency committed to tackling the sexual abuse of children in both the online and offline environments—with the principal aim of identifying, locating and safeguarding children and young people from harm.

7. CEOP has built partnerships with children’s charities, industry partners, education establishments, government departments and law enforcement agencies, both within the UK and internationally, to bring a holistic approach to tackling child sex abuse. CEOP also represents the UK in the Virtual Global Taskforce—an international alliance of law enforcement agencies set up to provide a global response to child sexual exploitation.

8. CEOP works alongside specialists, educators and investigators by adding value, expert knowledge and skills to the good work already taking place at the front line of child protection. The Centre is comprised largely of three main faculties—Intelligence, Harm Reduction and Specialist Operational Support, with all areas of work linking into each faculty. Specialist services can support agencies at home and abroad to protect and safeguard children, whilst at the same time holding offenders to account for their actions.

9. Affiliated to the Serious Organised Crime Agency (SOCA) and with powers that are derived from the Serious Organised Crime and Police Act 2005, CEOP works closely with all UK police forces in tackling this crime. For more information on the work of CEOP, please visit www.ceop.police.uk

SUBMISSION

The changing nature of sexual abuse

10. In CEOP’s experience, the significant growth of the internet and associated new technologies as well as the expansion in their use has changed the nature and profile of much of the sexual abuse activity that takes place.

11. It is clear that the online environment has created opportunities for those who wish to abuse and exploit children, as well as allowing access to a network of like minded individuals which in turn may encourage such offending. Internet forums and websites can provide a virtual community for offenders to chat to one another in order to reinforce distorted thinking about child abuse as well as to share practical advice about how to abuse children.

12. CEOP also knows that children are vulnerable in new and challenging environments and frequently put themselves at risk without realising the consequences. Offenders take advantage of the natural risk taking behaviour and vulnerability of children in online environments and use grooming techniques, posing as boyfriends, celebrities, and school friends to gain access to children.

The professional response

13. The feedback received from child protection services suggests that access to specialist resources such as CEOP have proven valuable to frontline police and social workers but very often local agencies are still struggling to recognise and act on this form of abuse, particularly in its early stages.

14. CEOP’s perception is that professionals working within child protection (including police and social workers) still have progress to make to ensure that specialist knowledge of these issues is fully integrated into their response and their investigative strategies. In many cases we find that there is a tendency to misunderstand or minimise the risks that children take in the online environment, and where offending occurs in this environment, professionals sometimes minimise the risks to children.

15. The way in which police forces deal with this crime varies across the UK. For example, some cases may be dealt with by one of the following:
   — Specialist child sexual exploitation teams.
   — Child abuse investigation teams.
   — Specialist on-line investigation teams.
   — Main CID offices.
   — Other.

16. This means law enforcement officers with variable levels of expertise and experience in terms of child safeguarding, child sex offender awareness and technical knowledge deal with these cases. It is therefore likely there will be a variety of responses and perhaps differing standards of investigation and safeguarding activity.

17. In general it is the case that in tackling online exploitation as well as offline exploitation there is a need for professionals to understand the risks involved in order that they can prioritise appropriately when they are dealing with high volumes.

18. Police forces in particular take an intelligence-led approach which results in the prioritisation of cases which obviously present as high risk—and there is a danger that some risk factors for online and offline sexual exploitation remain unrecognised.
Understanding of children's risk taking in the online environment

19. It is our experience that social work professionals often underestimate the risks that children face from putting information or sexual pictures and images online—a phenomenon known as “sexting”. There can be a tendency to regard this as a natural part of children's exploration and development without understanding the risks and permanency of the information that is uploaded and the ways it might make the children they work with vulnerable. An example of direct or immediate risk this behaviour can have includes children and young people engaging in sexting where they or their location—be that school or home—can be readily identified.

20. In particular, it is CEOP's experience that child protection professionals, and those working with children more generally, may struggle to identify situations where there are likely to be adult groomers or coercers involved in manipulating the activity of children and when it would be appropriate to involve police colleagues.

21. Research is also turning now to related issues, such as the ease with which children and young people can access indecent images and the potential adverse impact this might have upon them in later life—such as the potential for them to themselves to go on and offend. This is an area which needs to be further explored, including the linked issue of what effect exposure to extreme pornography has on children and young people.

22. Professionals working in social care need to be better equipped to routinely address children's behaviour online and show children ways that they can protect themselves from unwanted contact as well as get help.

23. CEOP's Thinkuknow programme has made considerable headway in reaching teachers and others working to educate children and young people, but there are a range of other professionals working directly with children who need to be better equipped with these skills—particularly those working with more vulnerable groups of children.104

Understanding the seriousness of non-contact sexual abuse

24. It is CEOP's experience that professionals often do not understand the harm associated with forms of non-contact sexual abuse. There is often a failure to identify the likely grooming that may have been behind children and young people engaging in risky behaviour—such as creating sexual videos or images—as well as the ongoing impact this may have on them.

25. The new forms of non-contact sexual abuse of children (where children are persuaded to undertake sexual activity via webcam and this material is then captured by abusers, distributed or made widely available on the internet) are qualitatively different from “traditional” forms of non-contact sexual abuse (which can include verbal harassment or indecent exposure) and are extremely damaging for children.

26. Whereas traditionally sexual abuse that does not involve touch may indeed be less harmful than abuse that involves greater physical contact, this new internet-enabled form of sexual abuse has been shown to have a range of features that are all associated with specific harmful effects. These include the widespread exposure of the victim, the permanency of the exposure, the involvement of blackmail and coercion and well as the partial participation of the victim in the activity which increases the sense of self blame and of betrayal.

27. CEOP’s experience is that the impact of this form of abuse is far greater than is widely understood and that this needs to be recognised by those working with children.

Risk assessments for offenders viewing images

28. Another issue where child protection professionals may need further support is in understanding the risks that those offenders who have been found viewing child abuse images present to either their own or to other children. The risk remains that the volume of work involved here diminishes the response, almost by default.

29. Some research studies suggest that the level of co-offending (between contact abuse and non-contact abusers) is high (Bourke and Hernandez, 2009) and that the majority of offenders who view images will either go on to contact abuse children or are already doing so. Others argue that those offenders viewing images who subsequently abuse children are a minority. A recent article by Michel Seto, Karl Hanson and Kelly Babchishin in “Sexual abuse: A journal of research and treatment” put together a meta-analysis which demonstrates the high level of divergence between studies.

30. One of the problems with much of the research is the reliance on recorded reconviction rates which is likely to underestimate the level of reoffending.

31. CEOP’s view is that looking at indecent images of children clearly indicates a sexual interest in children. The risk will always need managing, therefore, but additionally there is a need for better guidance and tools to risk-assess offenders as well as to understand the context of offending behaviour against children. This is particularly important in identifying whether offenders have involvement in any production and network activity, as well as previous offending history and current access to children.

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104 A core purpose of CEOP’s Thinkuknow education activity is to embed protective behaviours in children at an early stage, so that they learn early on how to navigate the online environment, get the most out of it but also to stay safe and know how to report. Alongside the resources it has developed for 8–16 year olds, CEOP has developed resources for 5–7 year olds which do not target sexual abuse explicitly but which aim to teach children some of the core principles in relation to staying safe, privacy and bullying and other key issues.
32. CEOP is currently in the process of producing a thematic assessment on this issue that may be used to better guide professionals in making these decisions.

Guidance

33. It is unfortunately the case that core guidance such as *Working Together to Safeguard Children* does not adequately address relating to the online environment. Additionally, the core assessment framework for social workers—the *Framework for Assessment for Children in Need*—does not incorporate an understanding of the ways in which children behave and explore in the online environment, and the vulnerabilities that this may create for them.

34. The issues of internet use within a household have not, for example, become part of a core assessment process for social workers. Within the *Working Together to Safeguard Children* guidance, the issues relating to internet offending are found almost exclusively at the back of the document in the section entitled “Child Abuse and ICT” and are presented as additional guidance on online safety rather than integrated into the section about complex abuse. This is despite significant numbers of cases that involve online networks. Local areas may need support in how an understanding of online networks of offenders should inform local complex abuse procedures.

35. CEOP has offered support in multiple complex abuse cases which involve a numbers of different police force areas and a number of different children’s services as a result of online offender networks that cross geographical boundaries. In such case it tends to be unhelpful to think about “online” offending as being separate to the actual contact sexual abuse of children that takes place, images of which are then shared through an offender network.

36. CEOP has identified considerable support that is still needed at both a strategic and practical level to understand and manage complex cases of this nature, particularly where there is significant contact offending facilitated and stimulated by online activity.

Trafficking

37. Another specialist area where professionals may need to be better supported is in identifying and responding to child trafficking.

38. As identified in our recent assessments on this issue, a lack of awareness and understanding of child trafficking as well as constraints on resources means that children who have been trafficked are often not identified as such and do not receive an appropriate child protection response.

39. Victims of trafficking are often particularly difficult to identify because they are hidden from mainstream services, and there is a need for LSCBs to ensure a proactive approach to trafficking locally which is joined up with efforts to tackle missing and exploited children.

40. Many victims of child trafficking who are identified by professionals and placed in local authority care subsequently go missing, only to be found in exploitation. There is a lack of understanding of good practice in safeguarding victims of child trafficking. Professionals should be better supported to prevent victims of trafficking going missing from care.

41. CEOP works closely with (and seconds a police liaison officer to) the NSPCC’s Child Trafficking Advice and Information Line to try to ensure that professionals are supported to identify child trafficking and progress trafficking cases in a way that will successfully remove children from significant harm.

Sexual exploitation

42. CEOP’s recent *Out of Mind, Out of Sight* thematic assessment on child sexual exploitation demonstrates that the child protection system in England is not well equipped to identify forms of sexual exploitation where young people are abused via localised networks.

43. This *Out of Mind, Out of Sight* assessment makes a number of recommendations relating to the need for early identification in sexual exploitation cases and earlier interventions. CEOP also identified a number of areas of best practice in this assessment, but found that in general public and frontline awareness of this form of sexual exploitation was low. Where there was no proactive approach to tackling this issue, cases were being missed.

44. A particular issue is that older children (often with multiple vulnerabilities) were not seen as meeting the thresholds for the child protection system, and not triggering investigation by either police or children’s services in cases of severe and what often transpired to be organised or networked forms of abuse.

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105 Strategic Threat Assessment Child Trafficking in the UK (2010); The trafficking of women and children from Vietnam (2011); Hidden Children—The trafficking and exploitation of children within the home (2011). All can be accessed at http://www.ceop.police.uk/Publications

106 Available at http://www.ceop.police.uk/Publications
45. The concept of “early help” also needs to be applied to older children who may not be as responsive or easy to engage, or as clearly vulnerable, as very young children, but who are in fact at risk of being very severely abused and exploited.

**Sharing of information**

46. Earlier this year CEOP provided evidence to the Munro review about the need for health services to share information relating to sexual exploitation and abuse.

47. Whilst all services need to improve their ability to identify and refer potential cases of sexual exploitation there is a particular lack of information from health services that explicitly needs to be addressed.

**Prevalence**

48. It is important to ask whether the child protection system in England is adequately set up to effectively identify sexual abuse, and to help victims. It is noticeable that registration numbers for child sexual abuse have declined in recent years, whilst at the same time there has been a rise in the levels of reporting and of convictions for sexual offences against children. However, it is important to be cautious in drawing conclusions about what these different measures actually tell us about the levels of sexual abuse and about the responsiveness of the child protection system as a whole.

49. CEOP’s judgement of the available intelligence is that it is in fact the case that many professionals are not identifying some of the most serious forms of sexual abuse. This is not to minimise the progress made by professionals in many areas, it simply identifies that this area of work remains highly challenging, and may even face a set of new challenges that are not well recognised.

50. The most recent NSPCC prevalence study does suggest a slight decline in serious forms of contact sexual abuse. However, the changing nature of the online environment means that new forms of non-contact sexual abuse are thriving. This is where children are groomed into performing sexual activities, which is then shared via the internet. This is a particularly damaging and pernicious form of abuse with research suggesting that the wider distribution of abuse material leaves children particularly damaged and distressed.

51. We already know that children are reluctant to disclose sexual abuse and exploitation, and so gaining a full understanding of the extent of sexual abuse is challenging. There is evidence to show particular problems with disclosure where abuse has been captured via video or images. Researchers and therapists believe that this is because children do not feel in control of the disclosure process and because of the heightened sense of shame and exposure.

52. Work at CEOP has uncovered networks of offenders sharing images of babies and toddlers. Pre-verbal children will not be able to disclose and are unlikely to be easily identified by professionals—our investigations in this area therefore lend more insights into the ways this may be occurring.

53. CEOP’s *Out of Mind, Out of Sight* thematic assessment suggests that many children (particularly those from high risk groups) disengage from protective services as a result of grooming and exploitation and therefore never become known to these services. When they do, it is unfortunately the case that older children are often not seen to meet the threshold for intervention because the nature of their exploitation is not fully understood.

**Conclusions**

54. Identification should not just be about the child protection system but about all frontline service providers who have a responsibility to identify and safeguard children.

55. All frontline services should be able to identify children at risk, and then have appropriate referrals routes through to the child protection system. Appropriate services are then needed.

56. In our experience therapeutic services can be difficult to access.

57. There are still difficulties in the identification and support to children who are trafficked into the UK.

58. As a final point regarding indecent images of children, any investigation of the possession of indecent images should provide an opportunity to:

- identify further offences that an individual may have committed;
- identify possible victims; and
- create a better understanding of the risk that individual poses.
Executive Summary

The effectiveness of the existing child protection system varies across England. Where social services work closely with voluntary sector Black, Minority Ethnic and Refugee (BMER) specialist organisations that assist vulnerable women and children in the areas of forced marriage, “honour”-based violence or female genital mutilation (FGM)—collectively known as “harmful practices” (HPs) in this paper—in addition to domestic violence, there has been more effective safeguarding and child protection work. A lack of a continuous working relationship between social services and voluntary sector organisations—which has been the norm—with contact being made only at crisis point, i.e., when intervention is necessary, creates barriers to effective work. As a result, social workers could potentially make decisions that are detrimental to the child. In addition, the serious lack of intelligence on the number of young women and girls who are involved in or have been affected by serious youth or gang related violence has a direct impact on the effectiveness of the child protection system in responding to girls who are at risk of these forms of violence. Continuous and appropriate training, to inform practice and approach is essential. The existing child protection approaches often fail to capture and reflect the depth and breadth of contemporary British cultural landscape.

Imkaan is the only national BMER second-tier organisation dedicated to working on violence against women and girls (VAWG). We have over 13 years of experience of working in the area of gender-based violence, which includes domestic and sexual violence, forced marriage and “honour”-based violence. Imkaan’s history, development and experience is grounded in the grassroots experiences and needs of services and the views and voices of the women and children they support. Imkaan works to ensure that the needs and views of the sector are highlighted to policy makers and other stakeholders, whilst also supporting the development of good practice and sustainability within the sector. Imkaan’s work includes strategic advocacy, training, capacity building and research. Imkaan recently completed a piece of work for the Greater London Authority on HPs, which is due to be formally launched at the end of this month at the House of Lords.

Factual Information

1. The evidence in this paper has been gathered from a number of sources:
   — Imkaan’s BMER Refuge Network members;
   — an organisation (DE) that raises awareness with young people, assists girls and women who are at risk of or have had genital mutilation carried out on them;
   — a nurse who has specialist clinical experience in working in the area of FGM and is currently working as an Independent Sexual Violence Advisor (IA) with a Sexual Assault Referral Centre, in the south west of England;
   — through its membership of the Female Voice in Violence Coalition, led by Race on the Agenda (ROTA), Imkaan has also contributed to ROTA’s work on women and girls who are involved in or have been affected by serious youth or gang violence; and
   — Imkaan’s recent work on harmful practices.

2. Members of the Imkaan Refuge Network come across the following forms of child abuse or exploitation in their work:
   — children witnessing or directly experiencing domestic violence (DV). This could include situations where the abusive partner uses children within the relationship to threaten and control women, instruct children to be verbally abusive or disregard boundaries their mother might be setting;
   — physical and emotional neglect;
   — emotional abuse;
   — teenage boys repeating the behaviour of abusive fathers;
   — policing and restrictions imposed on young teenage girls by their parents;
   — sexual abuse and rape of children (this could be perpetrated by the father or by multiple family members);
   — forced marriage;
   — “honour”-based violence;
   — sexual exploitation;
   — child trafficking;
   — cases of childhood sexual abuse; and
   — online exploitation.

3. The problems and issues identified and raised within our submission are connected and interlink across the four areas that the committee will be examining: effective identification of, and early help to, children at risk of different forms of abuse and exploitation; factors affecting the quality of decision-making; appropriate thresholds for intervention and joint working. The response of social services (SS) in different areas in England...
varies. Problems that have frequently been raised in our evidence relate to the need for consistent and more involvement with BMER VAWG services, and regular as well as appropriate training, would assist in promoting the interests of the child. Closer liaison with appropriate voluntary sector agencies is needed, for example, multi-agency safeguarding hubs have been piloted in Devon, and there is interest in having these rolled out nationally. It is essential that at this stage, voluntary sector partners, such as specialist BMER women’s organisations are seen as key actors in the partnership framework. Some members have expressed an interest in an SS lead, who would retain a specific expertise in gender-based violence, in particular, HPs.

4. Child protection policies and procedures of BMER VAWG organisations: Our members have their own child protection policies and procedures in place in order to identify child protection issues, and a few examples of their systems are as follows: (1) the recording system was not developed with SS and is not linked to theirs, but the organisation has a “raising concerns” form, which, when completed, is passed to the manager who takes necessary action; (2) staff receive training, there is an internal policy and procedure to be followed, clear “reporting” lines, management sign off and templates for referral letters; (3) one organisation has a child support worker who carries out an initial as well as risk assessment; (4) one member has developed their own comprehensive child protection system since they do not receive support from SS for the types of cases they come across, and staff are trained. The organisation employs a Child Protection Officer who is contacted in all child protection cases, a report is generated and sent to the director. This organisation developed an assessment form to identify child protection issues early on during the initial contact with the young person. There is follow up after one week to update the assessment form since sexual exploitation is not identified early on because the young person will not disclose information unless he or she trusts the worker; (5) the system has been developed within the social services standards and is linked into the SS referral procedures, which are very similar.

5. Lack of joint work with appropriate voluntary sector services and multi-agency working: One member noted that there is a tendency for SS to work with other statutory services rather than voluntary sector services that also provide support. Appropriate intervention is more likely to take place if SS works consistently with the voluntary as well as statutory agencies. Closer working with the voluntary sector would ensure that communication and the flow of information is strengthened and could prevent a child from staying longer in an abusive situation. One member commented that her organisation worked with a young woman who ran away from home, and each time she was brought back home she would run away again. In working with the young woman, the organisation discovered that she was being sexually abused, which was leading to a forced marriage. However, SS did not take into account these issues and the school authorities had not adequately identified these issues.

6. Where a voluntary sector organisation may be the second agency (after the statutory agency in terms of support provision) clear referral routes—with a shared case reference number with access to shared case information—would assist in all agencies working together to provide the most effective support in the interests of the child. Where there is multi-agency involvement, bureaucracy impedes effective joint work.

7. Some of our members have specifically noted that all agencies involved with the family should be included in case conferences. In addition, SS need to know which agencies exist, including their geographical location and catchment area as well as any specialist area of work the agency might do. It is vital to assess the background, history of the organisation’s work, including its ethos in which it works, to ensure appropriate inclusion of organisations in child protection work, particularly since newer organisations have been surfacing. Such knowledge needs to be disseminated, possibly as a part of induction, and information needs to be shared effectively within SS, SW placements in the voluntary sector. SS needs to perceive the voluntary sector as professionals who are experts in their field.

8. Lack of multi-agency training: this leads to a poorer understanding of risk factors. IA works in the south west of England where the clients she works with are potentially at risk of HPs. Her experience is that the level of understanding and awareness in that area is very low—which is markedly different from her experience of working in an area where staff were well-trained. The usual response when she has raised HPs is one of disbelief and denial that such forms of violence could happen in that particular area. IA works with individuals who experience sexual violence and in particular, childhood sexual abuse, and considers there to be a gap in the knowledge of most professionals around the issue of HPs. IA noted that it is important there is a clear recognition of when there is risk. Some families may say they will not carry out FGM but there may be pressure from extended family members. Rather than remove children, families need support in order to be able to protect their children. FGM, especially, is a form of abuse and it is too late once it has been carried out. SWs need to engage with families and work with them to ensure the practice stops.

9. One member commented about the need for training in her area (east London) on child abuse and exploitation and specific forms of abuse, such as sexual abuse, which would assist SWs in understanding how early sexual abuse can start. SWs lack DV training, and there is also a lack of leadership on DV within social services. If the SW has had training to identify risk factors she or he will be more able to question the referrer. The questions and risk factors are laid out in the safeguarding policies, so SWs also need to be familiar with these. In addition, training in listening to the child, rather than imposing an understanding of the child’s experience from the perspective of the SW, ensuring that the assessment process is child friendly, so that the child has a voice, and is not just a process that SS administers, is important.
10. **Inappropriate responses:** in a recent case, SS provided a male interpreter who spoke the wrong language and misunderstood the situation entirely. In this situation, if the member’s worker had not intervened, the child would have been removed unnecessarily.

11. **Dealing with behaviours rather than root causes:** in one case involving a young woman who ran away from home and was truading, the SS focus was on her behaviour at school rather than the root cause of her behaviour, which a member later identified as abuse by her parents. It was therefore unsafe for her to return home. However, SS were more interested in the fact that her running away meant she was not attending school and therefore was seen to be truading or having a behavioural problem, and took action in relation to that but did not address the reasons why she was running away. This member commented that often, with SS, there is a lack of understanding about the causes of actions. They deal with the effects because these are easier to address.

12. **Not knowing how to respond and variation in responses:** members have stated that even if SWs are trained in, for example, forced marriage and ‘honour-based’ violence, when a case is picked up, they do not know how to respond appropriately. One member noted that her organisation receives positive responses. The nature of responses can include a minimal response or a single referral service, which will decide whether to initiate child protection proceedings, to a heavily punitive attitude towards the mother. A culture of blaming the mother, with SWs taking a punitive approach to the mother by separating the mother from her child or threatening to return mother and child to her country of origin is not helpful. In addition, there have been instances when appropriate questions have not been asked or picked up at all, nor an understanding of or realisation that the risk can escalate. IA noted that it is important there is a clear recognition of when there is risk. Some families may say they will not carry out FGM but there may be pressure from extended family members. Rather than remove children, families need support in order to be able to protect their children.

13. **Poor (even potentially racist) attitudes:** one member commented that the dismissive and arrogant attitude of the SWs in her area had caused staff to question whether the approach was rooted in racism.

14. **The current system is too reactive and intervenes only in a crisis:** Imkaan’s recent HP study reinforces wider concerns about gaps in early intervention and prevention. Eg the system is more likely to respond to women who have already undergone FGM, rather than intervening with families where minors are at risk.

15. **There is a problem with the system being able to identify/flagging cases:** IA noted that in one particular case where the children might have been at risk of sexual abuse, it took four referrals before the case was picked up. Working within the south west of England where many of the rural communities are isolated and cases of child abuse within that area are potentially not picked up, IA informed us that at times, it has been difficult for her concerns about a potential child abuse case to get logged by SS staff. One member informed us that it has not been easy to speak to the most appropriate person, and it is difficult to ensure that concerns about potential child abuse cases are logged by SS. Yet, even when details of cases are taken, particularly in relation to HPs, a few members note that SWs do not really understand the urgency of the situation or risk level.

16. **BME SWs and working with BMER communities:** In smaller communities, the allocation of BME workers need to looked at more carefully in order to avoid putting women at risk—there is a chance that a social worker could know some of the women from some of the BME communities. In addition, SS need to raise awareness in the communities they are working with, and face-to-face interaction in this area of work is vital. Working with communities will assist in improving the working practice of SS in two specific areas: (1) to resolve any existing inconsistencies in its working practice; (2) to raise the awareness or understanding of the work that SS carry out with communities.

17. **Common Assessment Framework:** Some of the members questioned why the common assessment framework (CAF) was needed in many instances, and are unhappy with having to complete a CAF for every child that the organisation comes across as opposed to being given a responsibility, as professionals, to be able to make the decision about when a CAF really needs to be carried out.

18. **There is a critical lack of intelligence on the number of girls affected by gang violence:** this directly impacts upon the effectiveness of the child protection system in responding to girls who are at risk of these forms of violence terms.108 This oversight has meant that current child protection policy and practice is not able to address the impact of the serious youth and gang-related violence as a child protection issue.109 ROTA’s work on this form of violence revealed that gang associated women and girls rarely disclose any victimisation.

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they experience because of fears over reprisals, and the belief that their criminal associations would prevent them from acquiring state protection.110

19. Girls struggle to identify services that are independent of the state: with little or no confidence in any of the services’ ability to maintain confidentiality and to keep them safe. Given the lack of intelligence on these issues, statutory services are not clear how they should respond to gang-related sexual violence and cannot guarantee the safety of the girls once they have disclosed exploitation or assault when using standard safeguarding models. In addition, girls who carry firearms and drugs for their boyfriends will rarely be under any form of surveillance or be known to any specialist services such as children’s or youth offending services, and hence, rarely receive intervention and struggle to identify routes of support.111

20. Inability of child protection system in assisting girls affected by serious youth and gang-related violence: One of the key findings in the Rota 2011 report, which needs to noted, is that: serious youth and gang-related violence against women and girls is a child protection and safeguarding issue. In order to respond effectively, structures and processes need to be risk managed. Not only do girls need to feel confident in order to disclose, services need to be able and be confident to support girls in exiting gang-related and serious youth violence.

21. ROTA held roundtable discussions in five London boroughs, as well as a pan-London roundtable discussion on the statutory sectors’ response to serious youth and gang violence on women and girls. The participants of the discussions admitted that while they have a variety of models, structures and referral pathways in place for serious youth violence, sexual abuse, exploitation or domestic violence, none of these was directly transferrable to working with a girl affected by serious youth violence. Specific protocols or assessment tools for managing such situations in boroughs need to be in place before young women who disclose, would be made safer rather than be putting themselves at increased risk.112

Recommendations for action

22. There is a need for a multi-agency partnership approach, which needs to happen at the outset, with involvement of specialist BMER VAWG organisations. The multi-agency approach needs to integrate gender-based violence, including HPs, which are systematically embedded and integrated within safeguarding policies and practices and that responds to diversity issues. It is important for all agencies to work together and for each agency to understand the role of the others.

23. There is an urgent need to collate data on the number of girls affected by serious youth and gang-related violence. There needs to be better intelligence on children who are at risk of or are experiencing HPs.

24. All social workers and managers need to have training around HPs, different forms of gender-based violence and sexual exploitation, and be able to identify risk factors and act in accordance with policies. Policies need to be backed up with on-going training and raising awareness. Specialist agencies should be consulted for advice or training in terms of improving policies, procedures and decision-making. The expertise of the women’s sector should be used in mentoring and supervising SWs.

25. Personal contact with social workers with a ‘named’ person to deal with VAWG is necessary.

26. There needs to be a better understanding of the issues, and responses need to be better on diversity. A non-judgemental attitude is important and SWs need to be clear and direct with the family. A recognition that although HPs may be part of the culture and tradition within some communities, at the same time, families are placing children at risk—these are also forms of violence—as well as acting unlawfully, and need to be made accountable for their actions. In addition, where families are reluctant to engage or there are families with complex needs, provided this is appropriate, using trusted specialist BMER VAWG workers can help these families engage.

27. In light of the work on serious youth and gang violence, safeguarding and child protection strategies, guidance and procedures need to be reviewed to ensure that they consider the specific risks associated with gender and serious youth violence and that they address serious youth violence and associated sexual violence

110 ROTA 2010, Finding 3, p 7—see footnote 168 above.
111 ROTA 2010, Finding 4, p 8—see footnote 168 above.
112 ROTA 2010, 76—see footnote 168 above.
113 ROTA 2010, Recommendation 4, p 8—see footnote 168.
114 ROTA 2011, Recommendation 1, p 11—see footnote 169.
in relation to the under-18 year-olds. The impact of serious youth and gang-related violence is a child protection issue and should be seen as one in both policy and practice.

November 2011

Written evidence submitted by 4Children

INTRODUCTION

1. 4Children is the national charity all about children and families. We have spearheaded a joined-up, integrated approach to children’s services and work with a wide range of partners around the country to ensure children and families have access to the services and support they need in their communities. We run Sure Start Children’s Centres as well as family and youth services across Britain.

2. We develop, influence and shape national policy on all aspects of the lives of children, young people and families. As the Government’s lead strategic partner for early years and childcare we have a crucial role in co-producing policy with the Department of Education and representing the sector’s views and experiences. Our national campaigns, like Give Me Strength, change policy and practice and put the needs of children and families on the political and policy agenda.

3. Our family outreach workers work with parents in their own homes, providing help, advice and practical help and our specialist teams work to support vulnerable families experiencing drug or alcohol addiction, domestic violence and post-natal depression.

4. 4Children welcomes the opportunity to contribute to this important inquiry. There is no more important issue that how we can ensure the children and young people in the United Kingdom are kept safe from harm, neglect and abuse.

5. 4Children is concerned that the current debate about child protection is too polarised around the issue of whether or not children are taken into care expeditiously enough. Vitally important as this issue is, the risk is that it skews focus and resources away from the much larger group of children suffering from harm, neglect or whose life chances are being seriously compromised. These children will only be effectively protected from harm by the effective provision of the kind of “early help” or “early intervention” recommended by Professor Eileen Munro and Graham Allen MP but which is currently not a reality in too many communities, for too many children.

PRINCIPLES OF EFFECTIVE CHILD PROTECTION

6. The Munro report set out the following as the principles of an effective child protection system:

— Child-centred.
— Family usually the best place for bringing up children.
— Working with children and families.
— Early help is better.
— A variety of responses needed.
— Good practice is informed by research.
— Uncertainty and risk are features of child protection work.
— The measure of success is whether children are getting the help they need.

7. Professor Munro’s report also highlighted the value placed on reliability, honesty and continuity and on the importance of on-going support. This strongly resonates with 4Children research which showed that families felt very frustrated when professionals promised things they did not deliver; were not open with them about what was happening; or when services were “here today gone tomorrow”.

8. In addition to these principles, 4Children would add:

— Taking a strengths-based approach.

This means working from a starting point that recognises that all families have strengths which can be built upon. A strengths-based approach to child protection services means:

115 ROTA 2010, Recommendation 4, p 8—see footnote 168.
116 ROTA 2011, Recommendation 1, p 11—see footnote 169.
118 Ibid Pg 24
119 Ibid Pg 26
Deficit approach
Focuses on a family’s weaknesses, disabilities & dysfunction
Professionals—“do to”
Silo approach by agencies where families fall through gaps
Family members are clients and victims of problems—“do for”

Strengths-based approach
Focuses on a family’s strengths, abilities & capabilities
Professionals—“work-with”. Providing support for intrinsic change & self motivation
Collaboration between agencies with a truly integrated, web of support
Family members are citizens and active participants in solutions—“do with”

9. Professor Munro also rightly highlighted that the UN Convention on the Rights of the Child places a duty on states not just to intervene when neglect or abuse is taking place but also to provide the necessary support to reduce incidence of maltreatment.121 This makes it clear that providing an effective child protection system requires not just timely and impactful social work interventions but also a wider range of children and family services capable of meeting this objective.

10. Therefore, 4Children believes it is important that this inquiry does not focus too narrowly on the work and role of social workers—an area which has already faced considerable scrutiny in recent years from the Social Work Taskforce as well as Professor Munro—but instead considers the full range of services and professionals who work with families and children and the role that those services and interventions can play in keeping children safe and supporting families to thrive.

Consultation Questions

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation

11. The simple answer to this question is “no”. The system is not currently as effective as it must be. Too often Serious Case Reviews offer stark reminders of the cases in which not enough was done to ensure children were safe despite numerous opportunities to intervene—in spite of the best intentions of all those who work with vulnerable children and families.

12. In addition, as the Munro report makes clear an increasing emphasis on identification and assessment processes in the past has meant that not enough emphasis was being placed on providing the impactful support that can change children’s lives and de-escalate risk. This has meant that too many children are growing up in families where health, social and behavioural issues are having a detrimental impact on their well-being and long term life chances.

13. 4Children research122 shows that key causes of family instability and child vulnerability including postnatal depression, parental alcohol abuse and domestic violence are not being tackled effectively or early enough.

14. The Munro report makes many sensible recommendations about how to improve the system of child protection including reforms to the inspection system to ensure services are judged by the effectiveness of the work they undertake with children and families rather than the quality of their paper trail; a greater focus on developing capabilities within the workforce and recognising the value of good professional judgement; and the need for strategic re-shape in the way that child protection social work is organised.

15. We also support the work of the Social Work Taskforce and Board which over time are likely to improve the quality of social work practise and the morale of the profession.

16. However, we do not believe that even reform on this ambitious scale will be enough to bring about the kind of revolution we need to see in the way children and family services are delivered. It is our contention that simply improving the way the current system operates is not sufficient to see the step change that is necessary. Instead we need a more radical rethink about how you effectively deliver the shift to an early intervention and prevention approach—of the kind envisaged by Graham Allen and Frank Field—from the “foundation years” onwards.

17. There is now an overwhelming consensus in favour of this approach from policy makers, opinion formers, service providers and the public123 and yet the reality on the ground is that early intervention services are being scaled back in some areas as a result of spending reductions. With record numbers of referrals to social services about children and rising numbers of children in the care system many local authorities are focusing the overwhelming majority of their “non-school” resources on statutory social work and other highly targeted interventions.

121 Munro Report, Pg 36
122 4Children (2011) Crash Barriers: a new approach to preventing family crisis 4Children (2011) Suffering in Silence: how support for postnatal depression needs to be better
123 A survey commissioned by 4Children in May 2011 from Consumer Analysis Ltd found that 70% of the public agreed that “more money should be spent on preventing problems and keeping more families together”. www.givemestrength.org.uk
18. Breaking the cycle of spending on late—and in many cases ineffective—interventions will be like turning around the Titanic. But it must be done and 4Children believes it will only happen with sufficient leadership from Central Government—even in this era of localism.

19. 4Children believes that an important first step to this would be the adoption of Professor Munro’s recommendation for a new duty on Local Authorities and their partners to secure sufficient provision for early help and to set out arrangements for delivering this locally.\textsuperscript{124} We note that Government has said that it supports this goal in principle and is considering how best to give it effect.\textsuperscript{125} The Committee might usefully consider the options available to Ministers and the benefits of a statutory approach versus the alternatives.

20. In addition to this 4Children believes that there needs to be a strategic re-shaping of children and family services—universal, early intervention and targeted—so that they are based on the following foundations:

21. \textit{Seeing families as part of the solution.} Families 4Children interviewed as part of the Family Commission inquiry\textsuperscript{126} expressed their frustration at feeling like passive recipients of services. They felt their views were rarely sought on what they believed would be most effective in turning their family around. Families—even those facing considerable challenges—spoke of wanting to be more active in shaping interventions and solutions.

(a) This requires support that “gets behind” families and where relationships of trust can be established between families and professionals. Best practise identified by the Family Commission in Dundee, Knowsley, Camden and Cardiff showed how professionals can “get behind” families—focusing on the causes of problems in their lives, identifying what their capacity for change was and agreeing with them what had to be done.

(b) This is not a soft option. It challenges families on “what” and “why”, focusing on changing behaviours, with a clear contract with families to do all they can to turn their situation around to provide the loving, caring environment their children need. It means working with families to “get a grip” on their issues, identifying what they need to do to function more effectively and the support they need to do it.

22. \textit{Valuing the extended family.} Recognising that the extended family is a huge, untapped or underutilised resource in many families offers the potential for xx. An estimated 200,000 children are being raised by their grandparents, with many more grandparents providing huge amounts of emotional, financial and practical support, especially in tough times.

(a) 4Children has met grandparents who have taken in their grandchildren in the middle of the night to prevent them from being taken into emergency foster care. However, despite new guidance issued by the Department for Education reiterating that Local Authorities are under a duty to make arrangements for looked after children to live with relatives or friends where this is consistent with their welfare and that such carers should be provided with appropriate and necessary support, many still find that they have to struggle to get the financial and practical assistance they need from social services.

(b) One mechanism for harnessing the resource of the extended family that 4Children believes the Inquiry might usefully consider advocating is Family Group Conferencing (FGC). An FGC is a way of bringing the extended family and close friends together to try and address the problems a family is facing and achieve the best outcomes for children. It is a process, culminating in a meeting, which involves the whole family in setting out a plan for providing practical help and support to move forward.

(c) The key to the success of FGC is that the family is involved in the decision making. This creates more challenging but equal relationships with professionals, drawing on the extended family and friends as a resource. FGC is currently used primarily alongside the statutory child protection system or care proceedings. However, there is considerable potential for FGCs to be utilised earlier on in the process as a means of putting in place “early help” for families. This approach has the potential to increase the number of children who are able to be safely cared for within their own family but also could reduce the number children who require eventual referral to statutory services.

23. \textit{A strengths-based approach.} [see above]

24. \textit{Recognition of the role of universal services.} Universal services including schools, Health Visitors, Children’s Centres have a central role in identifying families that are struggling and where children may be at risk of harm or neglect as a result. Failure to recognise this risks failing children but also failing to “sweat” the significant assets that these services represent.

Supporting the wider children and family workforce to play this vital role is a crucial question to which the Inquiry should address itself.

One area in which the case for this is particularly strong is in the “foundation years” because this is a period in the life of many families when their interaction with services is at its most regular and intense and also

\textsuperscript{124} The Munro Review of Child Protection: Final Report (2011)
\textsuperscript{126} 4Children (2009) Starting a Family Revolution: putting families in charge.
because of the long term consequences of children’s early experiences. Government proposals in the “Supporting Families in the Foundation Years” paper for Sure Start Children’s Centres to have both a “named” Health Visitor and a “named” Social Worker will help build confidence in children’s centre staff to make appropriate and timely referrals where concerns exist. In addition, placing a greater emphasis on child development—physical, social and emotional—within the training of all professionals working with children and families will enable better identification of children who are falling behind or exhibiting challenging or concerning behaviours which may be early signs of neglect or abuse.

Universal services like Children’s Centres, particularly where they tap into peer to peer and other community based support, can play a really key role in providing the on-going support that families with multiple challenges need when targeted interventions withdraw.

25. Integrating services and breaking down silos. Families, especially those that are most vulnerable, tell 4Children how they can be overwhelmed by a plethora of professionals. Effective child protection demands a holistic whole family approach, with a lead professional bringing in the specialist experience and expertise needed to provide the practical help and support families need. Experience from the Total Place and local child poverty strategies shows that one of the biggest challenges in joining up services remains the challenge for partners in sharing resources and funding. The introduction and rapid expansion of Community Budgets offers a real opportunity to “crack” this problem once and for all, opening the door to wideranging service redesign and a shift to early intervention.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

26. Whilst believing wholeheartedly that many families can be helped to stay together with the right support, 4Children acknowledges that there are some families that are so dysfunctional that they do not provide a safe environment for bringing up children. In such cases swift action must be taken.

27. However, we unapologetically contend that much more can be done to challenge these small number of families earlier and provide them with the help and support to create a better environment in which children can be safely brought up. Placing children in care is both an expensive and traumatic solution and so it should remain a last resort.

28. 4Children believes that arguments about the thresholds for removing children from their families are important but that this argument currently dominates too much of the discourse about troubled families. The more significant issue that we believe the Inquiry might usefully consider is the threshold for support and intervention from social care and other targeted services which precludes many families from receiving the help they need to ameliorate the challenges facing their families and improve their children’s life chances. We understand that as a result of the spending climate and increasing demands on children’s social care teams, that in many areas these thresholds are actually rising—at a time when the political consensus in favour of early intervention and prevention should be leading them to fall.

29. The inquiry should consider how the various thresholds of support are being set by local authorities across England and how authorities including the 27 “early intervention” areas working with Graham Allen MP are attempting to redefine these thresholds by providing more seamless support from universal, preventative and targeted services.

30. In addition, 4Children believes that it is important to remember that the majority of children who enter the care system will return to the care of their family within a relatively short period of time and before they reach independence. Of the 68,000 children in the care system at any one time, around 28,000 enter the care of local authorities each year. This means that there is a turnover of more than one third in a calendar year. Much of the debate about the care system sees it as a binary state—either a child is in the care of their family or the state. Whilst this accurately reflects the legal position it fails to highlight the importance of maintaining family links for children whilst in care—especially with siblings and the extended family network, where parental contact is minimal or inappropriate. Figures suggest that 76% of children in care are separated from at least one sibling. This is in stark contrast to practise in Scandinavia where the local authority took on the care of the child “on behalf” of the family, with a formal contract with the family making it clear that they maintain responsibility throughout.

31. Even if the current debate and focus on ensuring more children are adopted is successful in this laudable goal, this will only ever constitute a fraction of children who spend some time in the care system. Therefore as well as debating what the thresholds should be for care we need an equal focus on how we support children and families to maintain family links and provide the on-going support necessary for successful reintegration—ending the revolving door between care and home which so many children currently experience.

November 2011

128 Children’s Care Monitor 2009, Ofsted.
Written evidence submitted by the National Deaf Children Society

KEY POINTS

Research shows that deaf children are at greater risk of abuse than hearing children.\textsuperscript{129}

Language and communication lies at the heart of a child’s social, emotional and intellectual development. If a child cannot communicate they will find it difficult to learn, develop positive relationships and make friends. They will be at risk of social isolation, poor mental health and poor life chances. Deafness is a barrier to language development and communication. Hence, they are defined as children in need in section 17 of the Children Act 1989.

As deaf children are at greater risk, the Government in 2005 recommended that “Area Child Protection Committees (now LSCBs) should review local procedures, policies and training programmes to ensure that the needs of Deaf children are recognised and can be met”\textsuperscript{130}. NDCS is unaware of any LSCB complying with this recommendation.

Since 2005:

(a) A Department of Health\textsuperscript{131} report (2008) concluded there was a “need to establish and improve the involvement of social care services available to deaf children.”

(b) Research by the University of Manchester (2010) highlighted major shortcomings in social care for deaf children in most parts of the country and a failure to recognise deaf children as children in need.

(c) The Munro review has specifically mentioned the vulnerability of deaf children.

Although concerns over the safety of deaf children and social care provision have been raised on a number of occasions since 2005, there is little evidence of the issues being addressed at a national or local level.

1. Introduction

1.1 The National Deaf Children’s Society (NDCS) is the national charity dedicated to creating a world without barriers for deaf children and young people. We represent the interests and campaign for the rights of all deaf children and young people from birth until they reach independence. There are over 35,000 deaf children in England.

1.2 NDCS has had longstanding concerns that deaf children and their families face significant obstacles in accessing appropriate social care services, even though deaf children are by law “children in need”. We welcome the opportunity to respond to the call for evidence by the Education Select Committee. NDCS has only responded to those areas where we feel it appropriate.

2. Background

2.1 Communication barriers can result in deaf children failing to develop good emotional health and well-being, being more vulnerable and in need of protection. Deaf children with permanent hearing loss are more than twice as likely to experience abuse as hearing children (there is also evidence to suggest that this figure may be as high as 3.4 times).\textsuperscript{132} In addition, over 40% will have mental health difficulties in childhood/early adulthood.\textsuperscript{133} This can be for a range of reasons including:

- the isolation that can be caused if a deaf child is unable to communicate with their family and friends;\textsuperscript{134}
- the fewer opportunities many deaf children have for incidental social learning and personal development, both within and outside of the family;
- the lack of appropriate equipment and advice to prevent deaf children from the risks of accident or harm. For example, a deaf child may not hear a fire alarm;
- the perceived inability of deaf children to communicate which can make them a target for abuse; and
- professionals failing to identify signs of abuse or mental health problems in deaf children because of communication barriers. If a deaf child is withdrawn, this may mistakenly be attributed to their deafness.


\textsuperscript{130} Dept of Health: Mental Health and Deafness: Towards Equity and Access, 2005

\textsuperscript{131} Dept of Health 2008 “Newborn Hearing Screening Quality Audit 2006–08


\textsuperscript{133} http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103995

\textsuperscript{134} 90% of deaf children are born to hearing families with little or no experience of deafness and 80% attend mainstream schools where they may be the only deaf child.
3. Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation

3.1 The National Deaf Children’s Society commissioned research from the University of Manchester on The impact of integrated children’s services on the scope delivery and quality of social care services for deaf children. This was published in February 2010.

3.2 This report raised serious doubts over effective identification and early help to children at risk. It concluded:

“In only a minority of Local Authorities would there appear to be effective, skilled and specialised social care provision for deaf children and their families.

There is clear evidence, on a widespread basis, of poor integrated children’s services arrangements in respect of deaf children and their families which results in a lack of specific attention to deaf children and families’ social care rights and needs; poor recognition of need and provision of assessment; severely limited ability to work preventatively within a broad understanding of safeguarding; ambiguous pathways of service provision; responsiveness only in situations of acute need; and lack of focus on the psycho-social developmental, linguistic and cultural challenges and differences of the full diversity of deaf children.”

3.3 In England, the Department of Health’s Newborn Hearing Support Programme Standard 25 states that:

“The social care needs of all families with a deaf child should be reviewed as part of an initial assessment by the lead professional. In all areas there should be available a member of social care staff with appropriate expertise in working with deaf children and their families to respond to the identified needs.”

3.4 However, a Department of Health report (2009) concluded: “there was still insufficient engagement by specialist children’s social care” and that there was a need to “establish and improve the involvement of the social care services available to deaf children and their families” and clarify “the role level and type of involvement and support the social care team could offer.”

4. Factors affecting the quality of decision making in referral and assessment and variations across the country

4.1 In its research the University of Manchester found “an extreme lack of specialist social workers with deaf children and their families employed in many local authorities” NDCS believes that this contributes to variation in the quality of decision making and assessment of deaf children.

“We muddle through. If we get stuck we contact the RNID interpreting service”. Respondent to the University of Manchester research

This is of concern because the respondent saw the issue as communication with the social worker rather that the child’s developmental needs associated with their deafness.

4.2 Despite the risk to deaf children, the University of Manchester found that a third of local authorities would not offer the family an initial assessment and over quarter said they rarely or never provided preventative services. “The formal recognition of deaf children as children in need as defined by the Children Act 1989 is far from universal amongst local authorities.”

“Senior managers just don’t get it ... A team manager who does not understand the situation of isolated Deaf youngsters would just refer it on and say ‘oh it’s an ordinary teenager’. We would say ‘loads of underlying issues’ He would meet the eligibility criteria for us.”

A respondent to the University of Manchester’s research into social care for deaf children

4.3 It can be difficult, without knowledge and skill, to distinguish the effects of deafness from the effects of neglectful or abusive parenting. Social workers need access to good quality training and specialist advice from other professionals including paediatricians and child psychiatrists who specialise in working with deaf children.

5. Whether the policies and practices of non social work agencies and Government departments assist professionals to work together in the interests of the child

5.1 The University of Manchester’s research found that in relation to deaf children:

— Only 6% of local authorities had joint management arrangements between education and social services.
— Only 10% had joint management arrangements with health.
— Only 50% of local authorities had systematic arrangements for ensuring that deaf children and their families received a joint assessment involving health, education and social care.
— Over 50% of local authorities said they had no formal referral arrangements between social work and health professionals where deaf children and their families may require assessment and/or service provision.

— In many cases where there were experiences of integrated working, this did not extend beyond the age of five.

5.2 NDCS is concerned that unless appropriate measures are put in place the decentralisation of health and education services could further exacerbate the problems outlined in paragraph 5.1.

6. Recommendations

6.1 NDCS recommends:

(a) The Government reminds LSCBs its recommendation made in 2005 that they review child protection arrangements for deaf children. NDCS has commissioned the University of Manchester to develop an audit framework to assist LSCBs.

(b) LSCBs must report on the effectiveness of local services to meet the needs of deaf and disabled children.

(c) Ofsted carries out a review of safeguarding arrangements of deaf children in local authorities. Following publication of the University of Manchester research report the Chief Inspector of Ofsted told NDCS of the intention to conduct such a review given the very significant findings from the research.

(d) Local authorities should have access to appropriately trained, skilled and experienced social workers who understand the implications of deafness so that they can undertake accurate and safe assessments

(e) To enable services to work effectively with deaf children and their families, local authorities and PCTs or health and social care trusts should have in place:

— a range of appropriate information and advice for families in appropriate formats and languages;

— an acceptance that deaf children meet the definition of children in need under the Children Act 1989. If the assessments under this legislation are not used, the responsible authorities must be able to demonstrate that they have assessment procedures in place which are as systematic and robust;

— staff in health, education and social care services who have a good knowledge of the implications of childhood deafness and a strong understanding of the positive developmental potential of deaf children;

— support to enable the family to develop their child’s language and communication, provision as necessary to develop parenting skills and support to access other services, such as national deaf Child and Adolescent Mental Health Services (CAMHS);

— provision of equipment and technology to promote independence and safety and assist communication; and

— support with the transition into adulthood.

November 2011

Written evidence submitted by False Allegations Support Organisation

Addressing the following points:

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to neglect, sexual and physical abuse, forced marriage, female genitalia mutilation, child trafficking and online exploitation) missing exploitation of children by their pornographic photographs on line (child pornography)—those highlighted are dealt with by FASO, the only one missing is children being used as pawns when a British subject (usually male) marries a non-British subject (usually female), going into women’s refuge, then accuses British partner of child protection issues, or sex allegations or rape in order to get their own British passport and live of the state.

Responder—we are the False Allegations Support Organisation (UK) (FASO) is a voluntary organisation dedicated to providing support to anyone affected by a false allegation of abuse—FASO is a refuge for the innocent not a safe haven for abusers in denial. The information provided has been taken from our telephone helpline cases from all over the UK.

Funded by voluntary donations and run by volunteers since September 2001—Parliament has said FASO make a difference.
Factors affecting the quality of decision-making in referral and assessment, and variations across the country

1. Each area in both England and the rest of the UK is managed differently, and investigations of those accused on child protection issues are often flawed. Each area deal with child protection issues differently, so transferring areas there is new investigations and assumptions made of incorrect recorded information.

2. Investigations of the issues are not carried out thoroughly, but by inexperienced persons without the necessary qualifications and often lacks evidential fact and information. The new child protection teams (be it different counties or the same) use historical information which can often be incorrect, instead of current gathered information. Common sense is not often applied.

3. There is no allowance for incorrect information being repaired, which lead to inaccuracies to the detriment of both the child and the family for life (PTSD).

4. Looked after children are not addressed for investigations in a similar way as those parents not having had social services input in the past.

5. Inexperienced case workers and those without children are made to address family issues without the experience of maturity and experience of childhood development. Therefore making judgements they are not qualified to make.

6. Extreme pressure placed on social services by the media highlighting the cases of damaged children under social services care, impacts on newly reported child protection allegations, with detrimental effect compromising fair and just investigations to newly accused families.

7. Independent family specialists, parents own doctors and specialists already treating children, health care workers etc. ignored in meetings, here social services maintain their dominance; they do not follow correct procedures because they know they are unaccountable for their actions. Family judges rule on presentations in court and are not interested in factual and corroborated evidence, creating further problems for the family unit.

8. Removing children from families without full evidential facts is tantamount to the state abusing the child (ren) and does not protect child (ren) but escalates their fears and long term psychiatric effects. As has been, and will be shown In the children taken for the satanic abuse cases where fears override evidence, where lessons have never been learnt, such as Cleveland 25 years on and those making the mistakes never held to account.

9. Information for parents to be empowered in knowing how social services work, being provided with names of experienced recommended solicitors, all of which should be provided by social services and are provided by FASO and other groups such as Parents Against Injustice (PAIN) www.parentsagainstinjustice.org.uk, FASSIT www.fassit.co.uk, FASO also provide a support help line and we spoke with over 3,000 families in 2010 regarding child protection issues and false allegations of sex abuse/rape, calls having increased annually since 2001.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

10. Intervention should only be made when full factual evidence, by investigation, has been carried out to include specialist reports (if this is the first indication of abuse) by both the local authority and independent reports by the family. To include the child’s history through their paediatrician and own doctor. All reports to be assessed in context by qualified persons provided by both family (legal aid) and local authority.

11. Children, when being assessed on child protection issues, should still have access to both parents, the person accused should not be made to leave the home. Nor the non-accused parent threatened with having their child (ren) taken from them if they continue to associate with the accused person (as happens, we are told, in many cases now). When the evidence and robust investigation proves that an abuse has taken place, only then should children be removed. In the case of both parents being accused Kin-care ship should be brought into place, where the kin-care is provided with foster care money for the keep the child.

12. If the child is placed in care of some description, the parent’s wishes on education/religion/ethnicity should be taken into account when placing the child in Temporary care.

13. Children newly born and in hospital (see www.aims.org.uk Maternity information on this issue)/or children in hospital, under medical investigation, can quite easily be monitored at the hospital and parents should not be removed, or the child removed from the parent—which traumatise all the family including the child for the rest of their lives. Nor should pressure be put on the families regarding child protection issues until the factual evidence suggest this is the case. (Also see 5% www.sbs5.diron.co.uk information/campaigner for parents on Baby shaking syndrome and brittle bones disease) also (www.parents-protecting-children.org.uk information on MSBP, Autism etc).
Whether the child protection policies and practices of non-social work agencies and Government Departments assist professionals to work together in the interests of the child

14. Professionals do not often work together from different departments in the interest of the child. For example, last night despite full factual written evidence over the past months a General practitioner of the family, having looked after the family for some years—mis-read a document, and instead of checking with the specialist author has taken a wrong assumption and reported the family as requiring child protection procedures. The child who has the problem has been taken from the family by social services, whilst leaving the older child with the parents. Both children are under four years. So no, professionals do not work together and certainly not for the child who needs its parent.

November 2011

Written evidence submitted by the Law Society

INTRODUCTION

The Law Society is the representative body for over 140,000 solicitors in England and Wales. We negotiate on behalf of the solicitors’ profession, lobbying regulators, Government and others on their behalf, and we work closely with a wide range of stakeholders to improve access to justice for the public.

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, FGM, child trafficking and online exploitation)

Early identification of, and help to, children at risk is a critical factor in achieving positive outcomes for children and families.

Although child protection and care solicitors become involved only after the identification of risk has already happened, they recognise that the effectiveness of the system relies on the experience, competence and judgement of social workers. The Law Society supports the recommendations in the Munro Review for maintaining experienced social workers on the frontline, and freeing them from centralised and prescriptive assessment frameworks.

The forms of exploitation and abuse of children are constantly evolving. New forms arise because of societal and technological changes. The Law Society believes that ongoing training and best-practice sharing nationwide are necessary to identify, and respond to, these emerging threats. The child protection system is probably not as skilled as it ought to be in identifying FGM, child trafficking and online exploitation, as some of those are relatively new to the English child protection system.

Factors affecting the quality of decision-making in referral and assessment, and variations across the country

The level of skill in social work staff in referral and assessment (R&A) teams is a key factor affecting the quality of decision-making. Legal practitioners have observed that many of the most skills social workers are allocated to the “children with disabilities” and “children in care” teams, leaving R&A to social work students/assistants and, in some cases, other unqualified staff.

The lack of proper resources for R&A, because resources are often put into other teams where risk is already identified and intervention has taken place, is a concern. Decision-making in R&A teams can be variable and of poor quality because the information gathering process and investigation are not as robust as they should be.

The Law Society believes that the current inspection framework is too rigid. Centrally prescribed time-scales should be removed, as should the distinction between initial and core assessment. Decisions should be localised, especially for assessment. There needs to be a more fluid information flow between different agencies, and more multi-disciplinary work across areas to decide on referrals. Continuity of social workers on cases should become the norm, as should a focus on improved communication with children.

Appropriate thresholds for intervention, including arguments for and against removing children from their families

The Law Society believes that the thresholds for intervention are right ie “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” (s.47 CA 1989 duty to investigate), and s.17 CA 1989 duty to provide services for children in need, and the threshold to be met when a local authority seeks an interim care order.

The Law Society is concerned that local authorities sometimes make applications for care orders and then do not seek an interim care order at the first or subsequent hearings because they are able to satisfy themselves that the child’s placement is safe (with parents or because a s.20 CA 1989 agreement has been reached) or that in fact they do not need to share parental responsibility with the parent. In those circumstances, solicitors are left wondering why the local authority could not work with the parent under statutory frameworks for child
protection case conferences/child protection plans or pre-proceedings stages instead of embarking on a court process.

The Law Society recognises that arguments for and against removing children from their families are complex, and that the right balance cannot always be struck. The political and media climate surrounding high profile cases has increased the pressure on all participants within the system, leading social workers to incline towards intervention.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

The Law Society believes that the current framework is too centralised, rigid and prescriptive. Targets, national indicators, and inspection regimes tend to focus on process and output, rather than outcomes. The lack of trust in the system, the drastic consequences of failure, and the media and political pressure have led social workers to lose confidence in their professional judgement.

Social workers must be provided with the freedom and confidence to make decisions based on proportionate and balanced risk assessments and professional judgement.

November 2011

Written evidence submitted by the National Council for Voluntary Services (NCVYS)

1. The National Council for Voluntary Youth Services (NCVYS) is the independent voice of the voluntary youth sector in England. A diverse network of national voluntary youth organisations and regional and local youth networks, NCVYS has been working since 1936 to raise the profile of youth work, share good practice and influence policy that has an impact on young people and the organisations that support them.

2. The NCVYS network reflects the diverse range of voluntary organisations working with young people at community, local, regional and national level. We cover around 80% of the voluntary youth sector in England and work with our members to build sustainable communities and services that help all young people achieve their potential. Most of our members offer opportunities to engage in challenging activities or develop creative talents. They also support young people to become active in their communities and offer opportunities for their voice to be heard. Some offer interventions to prevent or tackle specific issues such as homelessness or offending behaviour. Others offer counselling, advice, guidance and information. All contribute to young people’s personal and social development; some also engage with spiritual development.

3. NCVYS responded to the previous Government’s Lord Laming inquiry in 2008 and the recommendations we made remain relevant to ensuring that child protection policies of voluntary and community sector organisations work alongside other professionals in the interests of the child.138

4. Recommendation 1: To invest in training for all staff that work with children and young people to give them the confidence and skills to act in order to protect and safeguard young people. This should be supported by clear guidance issued centrally to Local Safeguarding Children Boards that requires them to support the delivery of appropriate training to the voluntary sector.

5. Recommendation 2: We need a stronger focus on preventative services and we need to actively engage the voluntary and community youth sector to cultivate stronger community networks which act as preventative safety mechanisms for parents and families.

6. Recommendation 3: We need to focus more on improving the quality of front-line practice across all services for children and young people and review the degree to which external inspection focuses on the quality of front-line practice as well as the framework for delivery.

7. Recommendation 4: We need to help everyone, at all levels, to understand how the systems of accountability work – so that everyone in the system understands where their responsibilities begin and end. In particular we need a review of youth work training to look at how child protection and the wider concept of safeguarding is being integrated into youth work.

8. Recommendation 5: We need to improve our current systems to ensure continuous performance improvement, so that our structures and our focus all bear down on how we can improve outcomes for children and young people.

9. Recommendation 6: We need to ensure Social Workers are supported by other professionals working with vulnerable children and young people to ensure a spread of skills and experience in managing difficult cases and areas of potential risk.

10. The recommendations in our response to the Department for Children, Schools and Families’ 2009 consultation Safeguarding children and young people who may be affected by gang activity can also be applied to safeguarding children and young people more widely.

11. **Recommendation 1:** Voluntary and community youth sector representation on local strategic bodies, possibly through local infrastructure organisations, is necessary to ensure a joined-up, holistic approach to safeguarding children and young people [who may be affected by gang activity].

12. **Recommendation 2:** Local Safeguarding Children’s Boards should engage a diverse range of young people in policy and decision-making. NCVYS’s principles of youth participation should be followed.139

13. **Recommendation 3:** Further guidance is needed to ensure that Local Safeguarding Children’s Boards make training available and accessible to voluntary and community youth sector paid workers and volunteers.

14. **Recommendation 4:** Solutions to safeguard children [who may be affected by gang activity] must take a “think family” approach which considers the needs of parents, families and carers as well as the needs of children and young people. This should operate in conjunction with support through individual interventions.

15. **Recommendation 5:** Government and local strategic bodies should utilise and support the development of resources produced by the voluntary and community youth sector to strengthen local partnership, in particular small voluntary and community youth sector organisations.

16. **Recommendation 6:** Organisations from all sectors need to be supported to develop safeguarding procedures, for example through NCVYS’s Keeping it Safe standards and Sound Systems accreditation scheme.140

17. More recently, NCVYS has welcomed the Munro Review and believes that it provides some well-evidenced recommendations which have the potential to improve child protection arrangements in England.

18. However we are concerned that the review’s focus on social work means that it fails to consider the child protection system as a whole and therefore does not adequately address the challenges within the health or schools systems. Consequently the challenges of safeguarding (older) young people are not satisfactorily set out in the Review. We echo the assessment of Carlene Firmin, Assistant Director, Policy and Research at Barnardo’s that young people over the age of 10 still need to be protected from violence and abuse.141 Early intervention to prevent future harm should be applied to young people of all ages.

19. NCVYS welcomes the fact that the Munro Review recognised that children and young people should “have a voice and be listened to”. NCVYS has consistently argued for principles of youth participation to be embedded in safeguarding work.142 In order for children and young people’s voices to be heard, investment in staff training and development for professionals working in safeguarding must recognise the importance of participation.143 We agree with the assessment of Bob Reitemeier, Chief Executive of the Children’s Society, who said, ‘This is particularly true of the professionals working with older children, which unfortunately does not get the attention it deserves, due to society’s focus on safeguarding infants... many professionals assume that older children are more resilient than they are, and consequently they do not provide adequate support to them.”144

*November 2011*

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140 See http://www.ncvys.org.uk/Safeguarding.html for more details

141 Child protection has forgotten the over-10s, The Guardian (Tuesday 10 May 2011) http://www.guardian.co.uk/society/2011/may/10/munro-review-child-protection-forgotten-over-10s

142 NCVYS has also consistently asked for this, eg Response to the Lord Laming Inquiry, NCVYS (December 2008) http://www.ncvys.org.uk/UserFiles/Policy/Position%20statements/NCVYS%20submissions%20to%20the%20Lord%20Laming.pdf


144 We must listen to the children, as Munro says, The Guardian (Thursday 12 May 2011) http://www.guardian.co.uk/society/joepublic/2011/may/12/bob-reitemeier-munro-report-listen-to-the-children
**Written evidence submitted by Enfield Safeguarding Children Board**

Name of person completing this pro forma: Angela Bent—LSCB development officer

**Consultation title**

New Education Committee inquiry: the Child Protection System in England

The Education Committee announced a new inquiry and call for evidence into the child protection system in England. Building on the Munro Review, and on the case for early intervention already made by the Field, Allen and Tickell reviews, the inquiry will consider the functioning of several aspects of the child protection system in England. Written submissions are invited, addressing the points below:

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<tr>
<th>Points</th>
<th>Comment</th>
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<td>Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation);</td>
<td>I don’t think that ‘the system’ should be the focus of the question. The system operates within a broadly supportable and effective legislative background. The Munro report talks about enabling local professionals to make decisions and that, to enable this to happen, the bureaucracy required by various arms of government needs to be relaxed. Along with the reduction of the bureaucratic burden, there needs to be a greater emphasis on the duty of professionals in other fields, particularly those who come into regular contact with children (GPs, schools, A&amp;E, etc.) to notify concerns. The Munro report also draws attention to risk aversion among the public and politicians and the blame culture when things go wrong. If we are to encourage more routine reporting of concerns, the process for doing so must be made easier—we cannot have a CAF for every low-level concern. The assessment process for referrals must also be simple and unbureaucratic, enabling swift initial assessment, leading to the vast majority of referrals not being progressed at all, but those that lead to concern having secondary assessment and, if necessary, intervention. I would seek to create simple notification of concerns, with the notifier (when that person is a professional) able to make their own assessment at the point of notification, with a two stage assessment process. The majority of notifications to be simply registered with a small number of higher risk cases subject to more exacting assessment. The danger with this approach is that apparently low risk cases become high risk. But, in the current situation, it is likely that these cases do not get notified at all. There is a need to link children and adult safeguarding assessment processes so that information can be shared. We need to be clear that adult safeguarding cases will often mean that children are affected. In addition, child safeguarding cases are likely to indicate and issue for adult(s).</td>
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<tr>
<td>Factors affecting the quality of decision-making in referral and assessment, and variations across the country;</td>
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Points | Comment
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— Appropriate thresholds for intervention, including arguments for and against removing children from their families; | There needs to be a greater ability to support families who fall below the S17 threshold but who are in danger of failing to provide sufficient parenting capacity. The concept of ‘parenting capacity’ itself could do with some clarification. The decision to remove children from families will always be difficult. The point at which the threshold is met is a mixture of the needs of the child, the needs of the family, the availability of the required resources, the local political environment, the national political environment and the current local/national context. Central Government needs to be clear about where it sees the threshold and it needs to be prepared to help with some resourcing if the threshold is to be markedly different from that which applies now.
— Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child. | I am unable to comment on this question.

Thank you for completing this consultation.

*November 2011*
Written evidence submitted by the Office of the Children’s Commissioner

OFFICE OF THE CHILDREN’S COMMISSIONER

The Office of the Children’s Commissioner is a national organisation led by the Children’s Commissioner for England, Dr Maggie Atkinson. The post of Children’s Commissioner for England was established by the Children Act 2004. The United Nations Convention on the Rights of the Child (UNCRC) underpins and frames all of our work.

The Children’s Commissioner has a duty to promote the views and interests of all children in England, in particular those whose voices are least likely to be heard, to the people who make decisions about their lives. She also has a duty to speak on behalf of all children in the UK on non-devolved issues which include immigration, for the whole of the UK, and youth justice, for England and Wales. One of the Children’s Commissioner’s key functions is encouraging organisations that provide services for children always to operate from the child’s perspective.

Under the Children Act 2004 the Children’s Commissioner is required both to publish what she finds from talking and listening to children and young people, and to draw national policymakers’ and agencies’ attention to the particular circumstances of a child or small group of children which should inform both policy and practice.

The Office of the Children’s Commissioner has a statutory duty to highlight where we believe vulnerable children are not being treated appropriately in accordance with duties established under international and domestic legislation.

INTRODUCTION

This response is guided by the work we have done in gathering the experiences and views of children and young people and is not intended to be comprehensive in scope. However, we believe that the points which follow are highly pertinent to the consideration of the needs of children and young people for a child-centred child protection system: one which is not just responsive but which facilitates their access to help in the context of their rights under the UN Convention on the Rights of the Child. The relevant Articles of the Convention are included below.

1. Does the child protection system allow for effective identification of and early help to children at risk of different forms of abuse and exploitation?

1.1 The early identification of risk and need relies on effective collaboration and a sound understanding of child abuse and child protection processes by the community, by universal services and by the wide range of agencies that may be in touch with children. Following on from the Munro Review, there is a need to address the ways in which the latter can contribute to ensuring that children and young people’s rights to protection are fully addressed (Articles 3 and 19). The Munro review identified much of what is needed for a child-centred system: above all listening to and observing children in order to fully understand their experience. That message has emerged strongly from our conversations with children who want their experience as well as their views to be taken seriously.

1.2 In her final report, Eileen Munro indicated that “early help” must include a timely response when problems occur at any age and not just a response to needs in the early years of a child’s life, however important that is. We thoroughly support this analysis and the need to ensure that equivalent priority is given to the wide ranging needs of vulnerable older children and young people as to those of young children. The former, for a range of reasons, might be less visible and less able or inclined to access universal services. We have a number of concerns about the identification of need and provision of early help, particularly in respect of older children and teenagers. There is evidence that the system is reactive rather than proactive and that young people have a number of barriers to overcome if they are to access services. There are serious doubts that the child protection system as it is currently structured is appropriate and accessible to young people and we suggest that, alongside the improvements proposed by the Munro Review, there should be further consideration given as to how services might be shaped for the older age group.

1.3 As evidence for the above we refer the Committee to research by The Children’s Society, which indicated a tendency for children’s social care professionals to assume greater “resilience” on the part of young people so that they did not need support and found that resource issues led to a lower priority for young people than younger children. Evidence from the NSPCC on young partner violence; from studies of gang related violence; the emerging evidence concerning sexual exploitation and evidence from the Department of Health national taskforce on Violence against Women and Children, all indicate the need for a tailored response to the specific needs of young people where they may be both victim and perpetrator (Articles 19 and 34). It is crucial that there are local strategies to meet these needs and provision to enable young people to escape from exploitation and abuse in order to support better recognition and initial responses. Without such exit strategies, young people will not be made safe and may be at greater risk following disclosure. Initial evidence gathered

by this Office and by the University of Bedfordshire indicates that the majority of Local Children’s Safeguarding Boards have not yet developed such local strategies.

1.4 There is evidence of serious neglect of young people, of mental health problems leading to serious self harm and of a lack of ongoing support to vulnerable teenagers who leave care. There is also a need to consider the best response to situations where the young person’s family are seeking their removal: a very different context from that where there is commitment to keeping a child, even though risks may lead to removal against parents’ will. The developing evidence on these problems indicates the need for both increased expertise among professionals and for appropriate services. Older children can be as vulnerable as the very young. They are not more resilient and capable simply because they are older. 

1.5 The evidence from Childline referrals and from recent prevalence studies indicates that many children and young people do not ask for help or protection from abuse. There are a number of barriers to requests for help—including concerns about the consequences—and we have commissioned research to facilitate better understanding and ways in which these can be addressed. There is a need to understand better the perceptions young people have as to what constitutes risk and abuse: evidence from our recently commissioned research suggests that children readily blame themselves for the problems in their families, and have a wide range of worries which need to be understood. Children worry about the consequences for their family of involvement with child protection services, may be drawn into conflicts and disagree with professional perspectives, and often do not understand the processes in which they are involved.

1.6 Young people have emphasised to us the importance of being able to establish relationships of trust, which can be sustained so that they are further able to disclose, and are supported in disclosing, abuse. An understanding as to how children and young people’s needs might be recognised by those within their networks, such as teachers, school nurses and youth workers, and how they can be linked into relevant services, is fundamental to enabling their protection, as is the opportunity to have sustained relationships with social workers once they are in receipt of support from children’s services. The latter is a constant thread from consultations and research into children and young people’s views of help.

1.7 Young people who have positive experiences of Family Group Conferences have told us of the value of working with the family to find solutions to problems at an early stage. There should be more effective ways of hearing children’s views and experiences in these meetings, including access to advocacy, and they have the potential to find a solution which keeps the child within the wider family: a solution which, if safe, can match the desire many children and young people have expressed, to stay within their family. (Article 12 addresses children’s right to a voice).

1.8 There is a need for further understanding about the needs of children living with parental substance misuse and mental illness and the services which might best support them, in addition to those which can best support the whole family (Articles 6, 24, 39). There is also a need for effective liaison between children’s and adult’s services working with these problems so that each set of professionals understand the full picture of family members’ needs and the risks to the children.

2. What factors affect the quality of decision making in referral and assessment and variations across the country?

2.1 There is inconsistency in the extent to which children’s experiences and views are taken into account in both referral and assessment (Article 12). Analyses of Serious Case Reviews have made this clear and children have conveyed this in many research and consultation responses. Barriers to children’s direct access to help have been mentioned above and include a lack of knowledge and understanding about the services which exist, mistrust on the basis of fear of the consequences, and a failure of response even when disclosures have been made. The latter, or the prospect of a lack of response, has been found to deter potential referrers. It is most important that children’s experiences and their views are well understood if a thorough assessment of risk, need and family dynamics is to be made by professionals. This requires observation and relationship skills and the ability to engage with children with a range of communication needs. Children have told us that they would expect teachers and GPs to notice abuse and neglect and to find a way to talk with the child, whether or not that child has disclosed.

2.2 Effective referral requires knowledge and understanding of what constitutes abuse and of available help and advice; straightforward means of referral and feedback; follow up and explanation; engagement with alternative networks of support where child protection intervention is seen as unnecessary or unsuitable and therefore effective interagency collaboration. Above all, if children and young people are to refer themselves for help, they must be informed of their rights to a service, assured of an appropriate response, listened to seriously and kept informed as to the outcome.

146 Stein, M Rees, G Hicks, L and Gorin, S (2009). Neglected Adolescents: Literature Review, DCSF
2.3 The assessment of risk and need requires a high quality of work and, done well, has been found to link to good outcomes for children.149 Several issues concerning poor practice have also been addressed in research and the analysis of Serious Case Reviews including: failure to engage the child; inadequate information gathering; insufficient analysis; and poor interagency working. A high quality assessment ensures the child is central to the analysis; draws on the history of the family and of previous intervention; is purposeful and timely and leads on to a clear decision.

2.4 Overviews of Serious Case Reviews (SCRs) have suggested that workers may develop “fixed ideas” about a case or adjust to a level of neglect which is unacceptable. With neglect, it is particularly difficult to make decisions about what is unacceptable, when practitioners may be balancing the parent-child relationship against the clear inadequacy of daily care. Research indicates the importance of a thorough review by a different worker to re-assess long term cases, in order to prevent the long term consequences for children of living with neglect (Article 19). Recent research has identified the neglect of young people as a serious problem requiring attention.150

2.5 We are concerned about delay in assessments, which should be timely for the child. Research indicates that the desire to give parents further opportunities can cause delay—often in the court process. The use of expert assessments can lead to delay in decisions about plans for children, particularly when there is repeated use of these, and their use can lead to the devaluing of social work assessments. There is a need to consider carefully what additional understanding can be gained through expert assessments. The assessment of the parent/s capacity and readiness to change within a timescale fitting to the child’s needs and age-related development is fundamental. While it is not possible to have certainty, professionals must be as well informed as possible from research and other knowledge. There is research evidence of the impact on the developing child of undue delay in decision making.

2.6 The above relates to the recruitment, training and supervision of social workers. Evidence based practice is vital: with evidence including that from the child’s experience. Issues of training have been addressed in the Munro report and link to the Social Work Reform Board agenda. In particular there is a need for sound understanding of attachment; early brain development; what constitutes resilience; the assessment of capacity for change in the context of domestic violence, mental health problems and alcohol abuse. This also needs to be matched by attention to training and support in other sectors, particularly health. Time for face to face work and the establishment of helping relationships which have been found to underpin effective social work, and which children have long requested, is essential to a child-centred system.

2.7 Much is known about what constitutes effective assessment practice and the context within which it can flourish. The improvement in terms of training; expertise; organisational culture; effective information systems will all hopefully be addressed by the work following the Munro Review. However, access to suitable resources to back up rather than limit assessments is also essential. Early help will depend upon the retention and development of relevant resources.

2.8 The Office of the Children’s Commissioner has been contacted by those concerned about the early removal of required timescales for assessment. This has been proposed by the Government in its response to the Munro Review. This followed Munro’s recommendations concerning the reduction of bureaucracy but we understood that there would first be an analysis of the implications of pilots for this approach, together with further consultation. While it is important to enable social workers and others to use professional judgment and they may need a longer period to fully assess the level of risk and need, there is currently troubling evidence of variation in the quality of practice. This should signal the need for caution pending the improvements intended through the implementation of other aspects of the Munro Review report. We cannot be confident that sufficient urgency will be given to the formulation of an initial judgement as to a child’s safety without the imposition of timescales. At the same time this is not enough. At a time of high level of referral and pressure on front line child protection services, there is a risk that that certain groups will be perceived as of less concern. Given the evidence previously referred to, we are greatly concerned that these will mainly be older children and teenagers. We have therefore suggested that the Government take time to consider further the preconditions for and timing of such a change.

3. Appropriate thresholds for intervention, including arguments for and against removing children from their families

3.1 Removing any child from their family is clearly an extremely serious step and should only be done if there is no alternative to ensuring that child’s safety and wellbeing. However, it is also important, as has been pointed out above, that there is not undue delay in making good decisions. The specific analysis of factors relating to each individual child must be at the core of decisions. Thresholds for action on referrals on the basis of risk appear to be influenced by pressures on available resources. This is of particular concern with cases of neglect and emotional abuse. The impact of lack of services will vary, in part influenced by the informal resources of support available to a family, and it has been argued that there is a need for further research in order to understand more fully which groups to focus on for early intervention approaches.151

149 For details relevant to following points see Turney, D, Platt, D, Selwyn, J and Farmer, E (2011), Social Work assessment of children in need: what do we know? Messages form research. DfE DFE-RBX-10–08
151 Turney et al. op cit
3.2 Negative views of the care system may be influential in the decisions made by professionals or the delay in such decisions. These may be based on evidence of gaps in educational achievement between young people in care and their counterparts in the community and other poor outcomes for young people. However, it is important to understand the background from which young people in care have come: it takes time and appropriate support, including therapeutic provision, to mitigate the early impact of abuse and neglect which preceded entry to care and may have been longstanding. Secondly, while the care experience can in itself generate problems, for example where there are changes of placement which do not arise from a child’s needs and where there is failure to provide timely security and permanence, it is still the case that many children have found that care gave them much needed security. Young people have talked of the value of the care experience and of the importance of the relationships they have made and are clear as to what makes for a good care experience. They have also spoken to us of the consequences of negative perceptions of care which lead to stigma when they seek to lead as “normal” a life as possible. Above all, there is an obligation on the state to make care a positive and nurturing experience which redresses the consequences of earlier problems (Article 20). The latter is by no means assured at present.

3.3 Much is known from research about what works both in permanent and short term placements for children in care; in particular the quality of carers or residential staff; stability and the opportunity to establish secure relationships. However, there is much still to be done to ensure that every child’s experience is as good as it can be. The early assessment of and planning for the needs of looked after children as they enter care is found by research to be a very suitable target for early intervention—before problems which pre-date care are exacerbated by an inadequate response from the system meant to redress them.

3.4 Young people who have been involved in research and consultations with us have made clear how important their families are to them. They have told us how important it is that there is clearly and jointly planned family support work which will enable them to have the best opportunity to stay with their family and that often such plans are not well understood by them and their parents. We know too that care leavers often return to their families, although the problems leading to separation have not always been resolved. These points make it essential that work is undertaken, before and after entry to care, to ensure as far as possible that children really do need to be there, and that children are able, as appropriate, to stay in touch with family members—including the extended family. There is an obligation to find care for children within the family network wherever possible: this will often require support, particularly where the child has developed behavioural difficulties (Articles 18, 20 and 26). A case in point is that of Special Guardianship, a route to legal security for children who cannot be parented by birth parents, and an alternative to care. There are many family members who will need financial and other support in order to decide to apply for this. The financial concerns, it is suggested, should not be permitted to outweigh the benefits to children when parental responsibility resides with those caring for them rather than retained by the state and birth parents, as is the case with foster placement. When children return to their families, that return needs to be as well supported as any placement in the care system would be. (Articles 18 and 26)

3.5 In considering the implications of entry to care, the different needs and trajectories for younger and for older children need to be considered. There is a need for timely decisions in every case but with the youngest children a decision as to permanent future plans needs to be undertaken with considerable urgency—the objective being security of attachment at a stage when this can have most impact on future wellbeing. There is now considerable evidence of the detrimental impact of delay.

3.6 Advocacy organisations have told us that they encounter reluctance on the part of children’s services to self-referrals by young people who wish to be accommodated as a result of family problems. Given the barriers to self-referral mentioned above, those who do ask for help are likely to be in desperate need of support. An effective response to young people in this situation may well pre-empt later mental health and other problems which have long term consequences not just for these young people but for their children too.

4. Do the child protection policies and practice of non-social work agencies and Government departments assist professionals to work together in the interests of the child?

4.1 Collaboration between agencies that work with or come into contact with children is essential to their protection. Communication, joint training and clear links between adults and children’s services are part of this. It is important to bring professionals in adult services, working with parents with substance misuse, mental health or other problems which impact on their children, into interagency safeguarding processes. The advances that have been made in links between children’s services and health and school professionals are essential to maintain and this will need vigilance with the advent of impending changes to both the structures within which the latter professionals work.

4.2 Schools play an important role in the identification and referral of risk and need and teachers may be the ones in whom children confide. Children have told us that school based advice can be valuable, particularly if it is discreetly provided and also that they expect that teachers will know them sufficiently to pick up on distress. This can of course be more difficult in secondary school. Further developments are needed in response to the emerging awareness of risk issues, as mentioned above. Secondary schools lack appropriate guidance and support in responding to violence in teenage relationships, and to peer-on-peer exploitation and abuse. Our

152 Children’s Rights Director (2010) Children’s Messages on Care, Ofsted
Ev w154 Education Committee: Evidence

early investigation of such issues has led us to question, for example, how child protection concerns can be managed when a complaint is not made to the police and therefore no charges are brought, yet schools continue to teach potential victims and perpetrators in the same settings.

4.3 In respect of health services, there is a need for GPs to be alert to signs of abuse and neglect as well as other health professionals such as health visitors and school nurses. These professionals are well placed to notice early signs of family problems and to identify poor relationships between parents and children. There is a need for them to observe and speak with children directly. Other professionals in child care settings such as nurseries will be best placed to notice signs of neglect as they see children on a regular basis.

4.4 Youth offending services are managing many child protection issues that they may not feel equipped to assess. The ASSET form is their assessment framework is offence rather than individual focused. The Youth Justice Board has planned to replace ASSET with a new framework that considers the vulnerabilities and risks to individuals but it is not yet clear when this will be undertaken. Given emerging concerns about exploitation and abuse of young people, this framework, and local strategies within which a suitable response can be formulated, are essential.

4.5 There is evidence that children and families where there are concerns about risks to children are not well supported when they do not meet thresholds for children’s services and that there is an increasing need for greater co-ordination for services working with troubling families who do not meet the threshold for child protection intervention (Articles 19, 32, 26, 39). The Local Safeguarding Children’s Board (LSCB) provides the strategic multi-agency structure to facilitate interagency working. However, when thresholds are not considered to be met, there may be no strategies in place to ensure co-ordination of response. For example, in one London Borough, the youth offending service introduced a multi-agency operational meeting to discuss young women and youth violence from a safeguarding perspective: this was initiated by a single member of staff rather than as a strategic decision. It is likely that, with increasing pressure on local authority services, and the loss of third sector organisations through financial pressures, together with the better identification of risk and need, such structures and strategies will prove vital to an effective response.

November 2011

Written evidence submitted by Serious Organised Crime Agency

INTRODUCTION

1. This submission provides details of the threat of child trafficking and efforts to tackle it within the child protection system.

2. The UK Human Trafficking Centre (UKHTC), which became part of the Serious Organised Crime Agency (SOCA) on 1 April 2010, provides a central point for the development of expertise and cooperation on combating the trafficking of human beings. It is the central intelligence repository on human trafficking and maintains a role in all investigations, through the provision of Tactical Advice Co-ordinators, victim care experts and specialist interviewers in respect of vulnerable, intimidated and significant witnesses. SOCA operates within the Government’s Human Trafficking Strategy, published by the Home Office in July 2011.

3. Estimating the number of children trafficked into and within the UK is difficult due to the hidden nature of this criminal activity. The risks of detection are relatively low and the level of investment required is small, making it an attractive proposition for organised criminals.

EFFECTIVE IDENTIFICATION & EARLY HELP—NATIONAL REFERRAL MECHANISM

4. Since the implementation of the National Referral Mechanism (NRM) on 1 April 2009, a large number of child victims of trafficking have been identified and supported. The recorded data held for potential trafficking victims under 18 years of age is potentially more accurate than that of adult victims, as the latter requires the victim’s consent.

5. NRM statistical data from 1 April 2009 to 31 March 2011 identified 390 potential child trafficking victims. Analysis of this data shows the most common type of child exploitation encountered by UK authorities is labour exploitation with 134 referrals, closely followed by sexual exploitation with 115 referrals, with similar referral numbers for both sexes. Victims of trafficking are not exclusively foreign nationals. UK national...
children, male and female have been trafficked also for sexual exploitation within the UK. Children are trafficked to the UK from a number of source countries including Vietnam, Nigeria, China and Eastern Europe. Whilst instances of child domestic servitude are recorded (52 referrals in the 24 month reporting period) the figures are not believed to be representative of the true scale. This is likely to be as a result of acceptance within some communities and the isolated nature of the victims’ captivity.

6. Once a child has been referred to the NRM, Local Authorities have a statutory duty to safeguard and promote the welfare of the child. This ensures that the agreed procedures and standards of care are implemented in the best interests of the child.

7. Separated and vulnerable children from abroad enjoy the same entitlements as UK-born or resident children. Some child victims apply for asylum and become categorised as an Unaccompanied Asylum Seeking Child (UASC). This process is handled by UK Border Agency (UKBA) case workers but is still monitored through the NRM process.

**Specific Issues Identified**

8. Unfortunately there is a trend for some child victims placed into local authority care to abscond and return to their exploiters; this is particularly seen in South East Asian and African victims. There are many potential reasons for this but these include a sense of duty on the part of the child or need to honour the repayment of “debt bonds” held against the child for their transportation to the UK, which is enforceable against the extended family in their country of origin. Rituals designed to force victims into compliance and threats of violence are among the controlling measures applied to the victims and their families.

9. The issue of victims absconding to return to exploiters has also been seen in the victims of internal child trafficking rings. While the potential reasons for this are numerous, one issue is that methods of identification and recruitment are known to attempt to drive a wedge between victims and their support mechanisms, be that friends, family or carers. The hold exploiters have over their victims is demonstrated by the contact, both telephonic/electronic and face to face, maintained by some victims rescued and waiting to give evidence in legal proceedings against their exploiters. SOCA, CEOP, and West Mercia Police are jointly looking at ways to support investigators and other child social services in the early identification of potential victims and the investigation of their exploiters.

10. In relation to children trafficked within the UK, such victims trafficked for sexual exploitation suffer further social exclusion as a result of behavioural changes induced directly by, or as a result of, the circumstances surrounding their exploitation. The exclusion has stemmed from significant changes in behaviour leading to sanctions being imposed at school and/or at home which in turn have further isolated the victims from familial, social and educational support networks, particularly for children already in local authority care.

11. In respect of the use of trafficked children for benefit fraud, the victims are often controlled by parents or relatives. They can be forced into acquisitive crime once their role in the benefit fraud is complete. The identification of these victims is difficult and normally only comes to the fore during investigations of the acquisitive offences.

12. Issues around the charging and prosecution of potentially trafficked persons are often exacerbated with child victims. Examples of this issue include the arrest and prosecution of Vietnamese national minors found in domestic Cannabis farms. The Government’s Human Trafficking Strategy contains a commitment for law enforcement to ensure that trafficked children found to be involved in criminal activity are dealt with from a child safeguarding perspective and not unnecessarily criminalised.

**Conclusion**

13. The UKHTC acknowledges the essential nature of cooperative working between Law Enforcement, Central Government, Local Government, private sector and Non-Government Organisations (NGOs) stakeholders in delivering the response to child trafficking. It is also critical to continue to build knowledge and understanding of the complex nature of trafficking and the psychological damage often suffered by the victim amongst the agencies responsible for dealing with it within the UK. In regards to the overseas response, the Human Trafficking Strategy sets out the commitment to work closely with international partners to improve enforcement and awareness-raising; working with overseas governments, international law enforcement agencies such as INTERPOL, Europol and Frontex, and local law enforcement in source countries.

*November 2011*
Written evidence submitted by Jane Ellison MP

1. Need for Accurate, Up-to-Date Figures

It seems clear that there is insufficient up-to-date information on the incidence of Female Genital Mutilation (FGM) in the UK. The best estimates we have come from research by the Foundation for Women’s Health, Research and Development (FORWARD), but these are based on statistics from the 2001 census. With migration trends to the UK from Sub-Saharan Africa over the last decade, where FGM prevalence is high (often 95%+ in some areas), it would suggest that instances of FGM are significantly higher now in the UK than the estimates based on the 2001 numbers.

Girls living in the large Somali population in the UK, for example, can be considered as being “at risk” as there is a high prevalence of FGM in Somalia. According to the most recent available data from the Economic and Social Data Service’s Labour Force Survey, in Q1 2011 there were approximately 110,500 people born in Somalia living in the UK (+/- 13,000), of which 69,000 were living in London (+/- 10,000). These figures do not give a gender or age breakdown and they exclude second generation Somali girls and women, who would be at risk of, or already subject to, FGM. If you include the immigrant communities from the other high-prevalence FGM countries, resident in the UK, there are a large number of girls who are living with or at risk of FGM.

The FORWARD report also said that there was an overall incidence of women giving birth in the UK with FGM, from 1.06% in 2001 to 1.43% in 2004. The report also found that in 2004, 6.3% of all women giving birth in Inner London had signs of FGM and 4.6% of women in Outer London.

It is clear that new up-to-date figures are needed to assess the scale of the problem, as a matter of urgency.

2. Need to Get a Prosecution for FGM

Despite being proscribed in law, there have, to date, been no prosecutions in the UK for FGM. Other countries have secured prosecutions, including some African countries, such as Ghana, Kenya, Senegal and Burkina Faso. It is a fact that FGM occurs in the UK, along with girls taken outside the borders of the UK by their families to have FGM committed (also illegal under the 2003 Female Genital Mutilation Act), so clearly the system is not working. However, for years great expertise has been brought to bear in successfully prosecuting child sexual abuse cases. It would seem clear that this expertise should be used in the area of FGM.

Securing a prosecution would send a very strong signal to families of at risk children that FGM is wrong and will not be tolerated in this country. FGM is committed primarily against little girls, most of who are below the age of 10. FGM is a form of child abuse and it should be treated as such.

3. Anecdotal Evidence

There is a great deal of anecdotal evidence to suggest that FGM is widespread in the country among at risk families and has been going on for some time. I have, in recent months, have had discussions with or received several letters, emails and postcards from people, some of whom are retired teachers or medical professionals, who have known of, or who have suspected FGM of taking place to children they have dealt with.

I include examples of this correspondence, below, which I would be grateful if you could consider as evidence.

Examples of correspondence sent to Jane Ellison MP regarding Female Genital Mutilation (FGM)

(Names of individuals have been removed before submitting as evidence)

Dear Jane Allyson (sic)

Heard article re: the cauterising of young girls. When I was in the East End 35 years ago it was well known that “this woman” did the procedure, you could hear the girls screaming. I informed social services, the police and anyone else that would listen but nothing was ever done, and it’s still going on. Will you be able to do anything? This is child abuse. Goodness knows what else these people are doing…

Mrs “X”
Barnstead, Surrey

22 August 2011

FORWARD, www.forwarduk.org.uk email: forward@forwarduk.org.uk Postal address: 765–767 Harrow Road, London, NW10 5NY. UK Registered Charity No: 292403


Figures supplied by House of Commons Library
Dear Ms Ellison

I am writing to thank you for your efforts to bring the issue of female genital mutilation into prominence.

I have long felt that this is a terrible crime against humanity, but it seems to be conducted as if the world does not care about its evil physiological and psychic (sic) damage.

As a retired teacher, I know how difficult it is for teachers to act on suspicions of abuse and cruelty (sic). Many head teachers are afraid of stirring up problems and the legal ramifications of confronting these brutal practices and teachers cannot act independently, but must take their suspicions to school management, who then make any necessary decisions. There should be a way in which teachers and other professionals can be more pro-active in acting upon their suspicions.

Thank you again for your efforts. Please, please continue.

Yours sincerely

Mrs “Y”
Walthamstow, London
16 August 2011

November 2011

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Written evidence submitted by Foundation for Women’s Health Research and Development (FORWARD)

EXECUTIVE SUMMARY

1. This submission from the Foundation for Women’s Health Research and Development (FORWARD) responds to the call for evidence for the Education Select Committee’s new inquiry into the Child Protection system in England. This paper addresses the key themes of child protection through the focused lens of female genital mutilation (FGM).

2. The areas within child protection systems that need to be urgently addressed include the lack of systematic data collection and analysis; gaps and lack of clarity in the UK legislation and policies pertaining to FGM and safeguarding; FGM within the wider context of child protection definitions and approaches; in respect of professional competency—in particular knowledge and training, cultural competency, coordination of interventions and roles and responsibilities.

3. FORWARD, the lead UK organisation working to end FGM, with over 25 years of experience welcomes the new inquiry and submits this evidence which aims to review the functioning of aspects of the child protection system with the view to ensure safeguarding of all children living in the UK irrespective of their cultural background and status. The Education Sector can play a crucial role in identifying risk and should be supported to take on this more effectively.

ABOUT FORWARD

4. FORWARD (Foundation for Women’s Health Research and Development) is an African Diaspora women’s campaign and support charity (UK registration number 292403). We exist to advance sexual and reproductive health and rights as central to the wellbeing of African women and girls. We work with individuals, communities and organisations to transform harmful practices and improve the quality of life of vulnerable girls and women, focusing in particular on female genital mutilation (FGM) and child marriage. Our vision is a world where women and girls live in dignity, are healthy, have choices and equal opportunities. More information can be found at www.forwarduk.org.uk.

5. FORWARD has over 25 years of experience of influencing UK policy and legislation and developing the capacity of statutory sectors and community and voluntary sector organisations to address FGM.

6. FORWARD is the UK partner in the END FGM European Campaign; which aims to place FGM on the European Union agenda. FORWARD is a founding member of the Women’s Health and Equality Consortium (WHEC) which is a strategic partner to the Department of Health; and an advisory board member of the FGM Special Initiative.

FEMALE GENITAL MUTILATION (FGM) IN THE UK

7. FGM (also known as female circumcision or female genital cutting) is “the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.” It is estimated that over 24,000 girls are at high risk of undergoing FGM and over 66,000 women live with the consequences of FGM in England and Wales.

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160 FORWARD (2007) A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales
Ev w158  Education Committee: Evidence

8. The UK defines FGM as a form of child abuse and violence against women and girls. FGM has been illegal in the UK since 1985 with the UK Prohibition of Female Circumcision Act. This was revised in 2003 with the Female Genital Mutilation Act, which introduced the element of extraterritoriality and increased the penalty for aiding, abetting or procuring FGM. The amended 2003 FGM Act has been in force since 2004 but there has not been any prosecution to date.

9. In many instances, FGM results in severe physical, psychological and sexual complications and affected women and girls require skilled, culturally sensitive and empathetic care.

10. FGM is not considered a mainstream problem in the UK—it is a minority issue that affects primarily migrants, refugees and asylum seekers and undocumented migrants. This adds to the complexity of addressing FGM in the application of current legislation and policies.

Child Protection system and effective identification of, and early help to, children at risk of different forms of abuse and exploitation

Data collection

11. There is currently a severe lack of systematic data collection and analysis on FGM by frontline professionals. This means that there is no comprehensive analysis of the extent or spread of FGM within the UK, nor any understanding of how FGM within the context of prevention and safeguarding is evolving. The lack of data means that professionals are often unaware that FGM is an issue within their work area and therefore key opportunities to safeguarding girls and support families are missed—with dire consequences for the girls involved.

12. The lack of data leads to lack of planning of work on FGM and so key services are ill-equipped to deal with (suspected) cases of FGM. This impacts the safeguarding and service provision and can mean that the process places additional and avoidable stress and anxiety on all who are part of the process (be it the frontline professional, the girl at risk, or her family).

13. The collection and analysis of data would provide an evidence based knowledge foundation to design and develop policies and programmes.

14. Recent data collection in the Department of Health on safeguarding areas are categorised under the four areas of harm. This lack of disaggregation of the data makes it difficult to identify and analyse and impedes a more targeted identification of girls at risk. There are pockets of good practice where some health authorities have chosen to collect this data, however, what is needed is a standardised data collection method and an effective monitoring and evaluation programme. Data collection should be consistent, accessible, recent, and dated (CARD).

15. As a state party to both the Convention on Elimination of All Forms of Violence against Women (CEDAW) and the Convention on the Rights of the Child (CRC), the UK has an obligation to take appropriate and effective measures to eradicate FGM/harmful practices, including the collection and dissemination of data on the practice (CEDAW General Recommendation no.14 and CRC Article 24). This implies that FGM should be viewed as a statutory concern.

Common Assessment Framework

16. The common assessment framework (CAF) is a key tool in identifying and assessing a child’s needs and providing a framework for multi-agency engagement and support. Within the context of FGM, the CAF has certain limitations, most notably that professionals need to have sound knowledge of FGM in order to initiate the assessment framework. The process is entirely voluntary and so families can choose what information to share, and even whether to engage with the process. Furthermore, this is not a risk assessment tool, and the prompts/indicators provided within the tool do not relate to FGM risk indicators. CAF as it stands cannot be adequately used for assessing risk of FGM and will need to be revised.

Factors affecting the quality of decision-making in referral and assessment

Knowledge/training

17. One of the greatest barriers to the safeguarding of girls at risk of FGM is the lack of knowledge and training of frontline professionals as to what FGM is, the consequences of FGM, the risk indicators, as well as the confidence and capability of addressing FGM. The Munro Review highlights the importance of “radically improving the knowledge and skills of social workers from initial training through to continuing professional development”. This is especially necessary for FGM as this is one of the most neglected topics within professional training and development.

162 FORWARD fully recognises the limitations of our own prevalence study due to lack of available data and systems to collect such data.
(a) Cultural competency

18. Cultural competence means being respectful of and responsive to the beliefs, practices and cultural and linguistic needs of diverse communities. There are five elements that impact the cultural competency of both an individual and a service, who must: value diversity, have the capacity for cultural self-assessment, be conscious of the “dynamics” inherent when cultures interact, institutionalise cultural knowledge, and develop adaptations to service delivery reflecting an understanding of diversity between and within cultures.\(^{165}\)

19. The capacity for cultural self-assessment is a particularly important element that often gets overlooked within professional training. A professional’s own cultural background and experience may impact the way in which they view and assess situations. Without minimising their professionalism, it is important to keep in mind this impact and appropriately compensate for this.

“There is this lady who has been circumcised. When she was pregnant, she was attending the local healthcare centre. When she gave birth to her baby girl, they sent her a letter telling her not to circumcise her daughter and that if she circumcised her, it would be against the law and she could go to jail. The woman found the letter threatening and she was very angry because she did not intend to circumcise her daughter. She was angry that the authorities assumed this just because she was circumcised. She wished the authorities had confronted her about her intentions instead of threatening her without knowing anything”. Quote from FORWARD Peer research (2009)

Immigration status

20. The 2003 FGM Act solely applies to UK citizens or permanent residents. While further legislation (eg the 1989 Children’s Act) protects all girls while they are based in the UK, there is a gap in equal protection. This lack of clarity on how UK legislation can be applied has led to key professionals hesitating in act of their concerns due to confusion of what safeguarding levers and mechanisms may be available to them.

21. Although there is anecdotal evidence that there have been over 50 cases\(^{166}\) investigated in 2009–10, there has been no information or analysis of these cases.

CASE STUDY A
A child’s mother has written to the school to request taking child out of school at beginning of July to return to Zimbabwe for “traditional practice” that is only performed during the winter season there.

Key points: The teacher has contacted social workers who have not got back to her. There are also concerns regarding the child’s immigration status as she is not a UK national or permanent resident, even through her Zimbabwean passport states her permanent address as the UK.

FGM as abuse

22. FGM as classed as child abuse in the UK. While there are a range of potential indicators that a child or young person may be at risk, these are not the “traditional” indicators of child abuse, and families involved may give no other cause for concern (for instance in their parenting responsibilities or relationship with their children).

CASE STUDY B
A child’s family is planning to travel to Eritrea for summer holidays and have requested that she leave school a week early. The Form Tutor alerted the Head of Year. The family is not in social care or have any other cause for concern. The school wishes to ensure that the child is safeguarded in country where FGM is of high prevalence.

Key points: Teacher only identified warning signs as had received prior training on FGM and therefore knew of increased risk during the summer time.

Roles and responsibilities of professionals

23. It is the duty of all professionals to act to safeguard girls at risk (Section 11 of the Children Act 2004). As has been highlighted through the training that FORWARD has delivered as well as the child protection queries FORWARD has received, many professionals are not aware of FGM, of how it relates to child protection issues within the UK, or of their roles, responsibilities and duties.

24. A recent case review conducted by the Metropolitan Police identified problems including a breakdown in inter-agency communication and partnership, as well as lack of recognition and ownership of their roles and responsibilities by all parties.\(^{167}\)

CASE STUDY C
A child’s mother has fed the father due to domestic violence and is not in a refuge. The child’s mother claims that the father has said that he will take his daughter to Nigeria for FGM although he

\(^{165}\) London Safeguarding Children’s Board (2011) Draft—Safeguarding children in minority culture and faith (often socially excluded) families, communities and groups—supplementary guide.

\(^{166}\) Hansard HC Deb, 15 September 2011, c1175

\(^{167}\) Metropolitan Police FGM case debrief report
Ev w160  Education Committee: Evidence

has only said this to the mother and not to the social worker. Each child has a UK passport, mother is a Nigerian citizen.

Key points: Mother’s social worker is aware of the situation and has not acted to set up a Strategy Meeting or alert the police. Furthermore, the social worker is leaving her post the next week and it is not known who will take on the case. The child has a UK passport although the mother does not and there is concern that the mother will not be able to remain in the UK to care and protect her daughter.

Appropriate thresholds for intervention

25. Early intervention requires all key professionals to be able to identify and act upon the possible indicators. This ability to intervene early and effectively relies on professionals have the appropriate training and knowledge to engage confidently and effectively.

Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

26. The publication of the FGM Multi-agency guidelines is aimed at providing information, advice and support to frontline professionals, even though they do not include any plan for dissemination to key professionals or training. Yet the ability of frontline professionals to identify warning signs and to have the confidence to act appropriately and sensitively is vital in order to safeguard girls at risk. Since the publication of the Guidelines, FORWARD has delivered training to frontline professionals (including police officers, teachers, and social workers) and rarely have these professionals been aware of the Guidelines’ existence.

27. The lack of a government focused strategy on FGM has also created difficulties in shaping joint working in addressing FGM, in France the early adoption of a strategy helped improve the safeguarding environment and role of professionals in tackling FGM, as at 2010 over 37 prosecutions had taken place specifically on the grounds of FGM. To date UK does not have a long term comprehensive strategy on FGM.

28. Engaging communities is central to tackling FGM and there has not been any strategic work with communities in this regard as such schools have a potential to liaise better with affected communities and help reach out to protect those at most risk. FORWARD is collaborating with the Primary Care Trust (PCT) in Bristol on an innovative partnership programme on safeguarding which works with community organisations and statutory agencies. This is funded by the PCT.

Recommendations for Action

29. Training of frontline professionals on FGM and cultural competency.

30. For this training to be incorporated into qualification learning, and continual development.

31. Better understanding and dissemination through training on the use of the Multi-agency guidelines.

32. Better understanding of roles and responsibilities of professionals by professionals

33. Examination of the CAF to see how can be amended to better identify FGM prevention cases.

34. Standardised data collection and an effective monitoring and evaluation method to analyse the data.

35. Guidance in schools for safeguarding leads on tackling FGM as a safeguarding duty.

October 2011

Written evidence submitted by NHS Confederation

INTRODUCTION

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

We are pleased to submit evidence to this inquiry. We have consulted with our safeguarding sounding board made up of designated professionals and members for this consultation and throughout the health and local government reforms. Our submission addresses the issues they identified. It focuses on issues relating to the health service and does not cover social care specific issues such as thresholds for intervention.
1.0 Executive Summary

— The NHS Confederation is deeply concerned that safeguarding and child protection have not yet been adequately addressed in the Government’s reforms of the NHS, public health and social care. Although the current system does need to improve, the progress made in safeguarding the most vulnerable in society over the past few years, such as an improved serious case review process and greater joint working between health and local government, must not be lost as the reformed system develops.

— The term “safeguarding” incorporates prevention and early intervention as well as child protection and we would like the overall safeguarding system to work more effectively. It is not clear in the reforms who will be responsible for what in terms of the safeguarding systems and commissioning safeguarding professionals in the health service. Therefore it is unclear how different professionals and organisations within the NHS and local government will work together to keep children safe.

— Committee members will be only too aware of examples of the dire consequences of failures in child protection. Previous failings in safeguarding, such as the Peter Connolly case, show the dangers of a disconnected system. The NHS has an important role in safeguarding and it is therefore essential that the new organisations which will make up the health service, such as Clinical Commissioning Groups (CCGs), make safeguarding a priority. NHS organisations will need to be connected to other parts of the system, such as local government, as well as each other.

— Currently, the number of vacancies for professional safeguarding nurses is rising and the system is failing to retain health visitors. Focussing solely on increasing the number of health visitors will not improve the child protection system; the Government also needs to ensure existing safeguarding nursing posts are filled.

— We urge the Committee to recommend the Government address safeguarding and child protection within their reforms of the NHS, public health and social care urgently, particularly given changes to the NHS are already underway.

— We have detailed recommendations to ensure effective safeguarding and child protection both in the new health system and during the transition:

- Arrangements for the transition to the new system must protect existing levels of expertise and networks amongst specialist safeguarding professionals and retain current safeguarding partnerships between health and social care. We recommend the Department of Health ensures the numbers of safeguarding professionals, particularly for Looked After Children, are monitored and maintained during the health reforms.

- The recommendations of the Munro review should be implemented by the Government. The review sets out holistic reform of the child protection system and if implemented will allow local leaders to design and deliver services to improve the outcomes of children.

- Health and wellbeing boards should play a key role in ensuring the needs of children are met by connecting the relevant parts of the system. We recommend these boards establish a specialist subgroup responsible for the integrated children’s service and safeguarding, which clearly links with Local Safeguarding Children’s Boards (LSCBs) and relevant non-statutory bodies.

- Clear mechanisms need to be developed for CCGs to work closely with their LSCBs and local authorities, especially where CCG boundaries differ from those of local authorities, something which makes collaboration harder. CCGs will need support and guidance from the NHS Commissioning Board to include safeguarding and child protection effectively when commissioning.

- The system for protecting vulnerable adults and children needs to be joined up in order to protect vulnerable families. The government must ensure safeguarding for both children and vulnerable adults is part of the outcomes frameworks for public health, social care and the NHS in an explicit and coherent way in order to encourage focus by both providers and commissioners on good safeguarding practice. Similarly, GPs’ responsibility for safeguarding should be strengthened when the Quality and Outcomes Framework (QOF) and the GP contract are revised.

- It is not clear how named and designated professionals will be commissioned in the new system. To sustain this vital role, we recommend that:

- The existing commitments for every provider to identify a named doctor, nurse, midwife (as appropriate) or other health professional (for ambulance trusts, NHS Direct and independent providers) must be maintained throughout the reform process and reflected in any national model contracts.

- Safeguarding professionals within the health service should be jointly commissioned by clinical commissioning groups and local authorities. These professionals will continue to be hosted and employed by NHS organisations. Jointly commissioned posts will ensure efficient use of this specialist service across areas larger than those covered by CCGs.
2.0 Health and local government reforms impact on early identification and early help for children and young people

2.1 Currently there is a significant amount of change within the NHS and local authorities as a result of the health and local government reforms. The Munro review’s recommendations, the government’s response, the reorganisation of the NHS—clustering of PCTs and SHAs—and the proposed reforms for children with special education needs and disabilities provide a complex picture for early intervention and early help services. The complexity of the current situation needs to be taken into consideration when thinking about the existing and future safeguarding system. The term “safeguarding” incorporates prevention and early intervention as well as child protection and we would like the overall safeguarding system to work more effectively.

2.2 We welcome the Government’s positive response to the Munro review, which accepted all fifteen of the review’s recommendations. We look forward to details on how these recommendations will be implemented. The NHS Confederation was involved in multi-agency discussions as part of the review and we particularly welcomed the Munro review highlighting the importance of the NHS for safeguarding children. Further clarity is required from the Government about how the review’s recommendations will be organised across health and local government systems and who will be responsible and accountable for making it happen. This could be a role for health and wellbeing boards at a local level.

2.3 We are pleased to see the recent Government commitment to maintain schools’ duty to work with councils to improve children’s welfare. This will help schools to be accountable and linked into the health and local government systems with regard to their safeguarding responsibilities. In order to ensure the safeguarding system works well we suggest that health and wellbeing boards as well as Local Safeguarding Children’s Boards (LSCBs) should play a role in this area. Schools will have to work with health and wellbeing boards and LSCBs for the delivery of appropriate child protection services. We also recommend that:

— schools take part in the development of the Joint Strategic Needs Assessment and the new statutory joint health and wellbeing strategy led by health and wellbeing boards;
— support is provided to schools, local authorities and health and wellbeing boards to develop joined-up ways of working such as sharing good practice. Ideally this support should be sector led; and
— schools are required to provide appropriate child protection and safeguarding services for children and measured through the inspection regime. They will need to ensure school staff are well trained in safeguarding.

2.4 The emphasis on early help should not just be about the early years but ensure early intervention is provided to children, young people and their families. Young people must not be missed out of the new system. The early intervention grant established by this government should be helpful at supporting families with the most pressing needs but ensuring provision of universal services may have more of an impact. For children who are not school age, health professionals are often key in early identification and therefore recognition of this, with appropriate training in understanding the signs and what to do, is vital. Greater collaboration between health professionals including community nurses, school nurses, family nurse partnerships and health visitors is needed. However, it is unclear how this collaboration will happen during the transition to the new system.

3.0 Factors affecting quality of decision-making in referral and assessment

3.1 The quality of decision-making in referral and assessment is about staff having the understanding, experience and access to specialist advice. Currently, due to the reforms, many of the structures and teams that support this are being disrupted. There is clear evidence that local areas which use multidisciplinary teams have been successful in improving child health. Given the range of agencies involved in child health, a sophisticated approach which brings the whole system together is needed. We argue that multi-professional teams should be required to work together to tackle problems which impact on the whole family (mothers and fathers as well as children and young people) while strengthening preventative and early intervention and improving outcomes, referrals and assessments. One group of professionals, such as health visitors, working in isolation is not sufficient to fully address the problems faced by vulnerable children. Currently, the number of vacancies for professional safeguarding nurses is going up and the system is failing to retain health visitors. Focusing solely on increasing the number of health visitors will not improve the child protection system. Other professionals such as midwives, GPs, CAMHS staff are also key to strengthening support for children and young people. Although the Government’s commitment to increase the number of health visitors could support a whole family approach, we do not believe that in itself is a sufficient response. It is not clear how the safeguarding system will be strengthened to address the needs of vulnerable young people. This group will not necessarily be in a household visited by a health visitor.
3.2 Clinical commissioning groups (CCGs) will play a key role in the new system. It will be essential to support CCGs to integrate child protection within commissioning decisions in order to ensure robust reporting and accountability arrangements at board level. There is a need to support appropriate referrals and assessments. GPs as providers also need support. The revision of the Quality and Outcomes Framework (QOF) and the GP contract will be an opportunity to ensure that the profile of safeguarding is universally raised within general practice and GP safeguarding responsibilities are strengthened; this opportunity must be taken. The NHS Confederation recommends:

— the new QOF should include strengthened outcomes for GP engagement in local safeguarding arrangements;
— the NHS Commissioning Board will need to provide guidance to clinical commissioning groups on their responsibilities for safeguarding and adhering to safeguarding standards when commissioning health services; and
— The existing commitment for every provider to identify a named doctor, nurse, midwife (as appropriate) or other health professional (for ambulance trusts, NHS Direct and independent providers), who is responsible within their organisation for safeguarding, must be maintained throughout the reform process and reflected in any national model contracts.

3.3 The NHS, Social Care and Public Health Outcomes frameworks provide a mechanism for monitoring effectiveness of referrals, assessments and interventions. At present the proposed Public Health Outcomes Framework contains one element on safeguarding specifically targeted at children under-five years of age and the Adult Social Care Outcomes Framework contains one element around adult safeguarding. The NHS Outcomes Framework has no elements relating to safeguarding directly. We are therefore concerned these frameworks will have gaps and be mis-aligned, and will lack cross referencing to other guidance.

— The NHS Confederation urges the government to ensure that the issue of safeguarding for both children and vulnerable adults is part of the outcomes frameworks for public health, social care and the NHS in an explicit and coherent way. This would encourage focus by both providers and commissioners on the preventative and protective elements of safeguarding practice.

3.4 Health and wellbeing boards form an important new structure to join up working between local authorities and the NHS. The success of health and wellbeing boards to bring together health and local government systems will be judged upon the collective leadership and the way in which board members work together. Strong collaboration, partnerships and clear links with LSCBs and other non-statutory bodies such as children’s trusts or voluntary group forums are required to strengthen referral and assessment processes. Formal mechanisms are also needed to ensure joint working between the different parties in health and local government responsible for children’s services, including social care and education, that link to adult and family services. Therefore we recommend:

— Local areas establish a specialist subgroup of the health and wellbeing board to encompass responsibilities for providing integrated children’s services and safeguarding, that clearly links with the LSCB and other non-statutory bodies.

4.0 Child protection policies and practices of non-social work agencies and Government departments

4.1 Safeguarding is a specialist field of expertise, the necessary knowledge and skills of which are not commonly found amongst generic health and social care professionals. Named and designated professionals perform an important function and act as a point of contact for staff in the NHS, social care, schools, other partners and the public. There should be recognition of the need for these skills in the future and a succession plan which enables training for them to be an integral part of workforce development and leadership within the health service. The NHS Confederation recommends:

— Networks for named and designated professionals to learn from each other, discuss issues of common interest and concern and develop new local guidance, such as those that have been provided by Strategic Health Authorities, should be maintained and supported by providers and commissioners locally. We suggest the local arms of the NHS Commissioning Board would be able to provide this function.

— The NHS Leadership Academy should support the leadership programme for named and designated safeguarding professionals.

4.2 The health reforms will disrupt established safeguarding mechanisms and work is required to ensure safeguarding is integrated within all commissioning decisions. In particular, it is not clear how commissioning named and designated safeguarding professionals in the health service will happen in the new system. We would expect the NHS Commissioning Board to provide clarity on this as a matter of urgency. An Association

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160 The public health outcomes framework will be published by the Department of Health October/November 2011.
of Directors of Children’s Services (ADCS) survey of LSCBs found that 25% of respondents felt the transition process as a result of the health reforms had reduced effectiveness of support by safeguarding professionals to LSCBs. The survey also highlighted the importance of designated professionals. 25% of LSCB respondents attributed any increase in effectiveness of support being due to the individual commitment of the designated lead and 32% of the boards specially noted and recognised the value of designated roles for the future. 

4.3 Clarity is needed in the transition arrangements to protect existing levels of expertise amongst specialist safeguarding professionals. To ensure efficient use of specialist functions such as safeguarding, the body responsible for commissioning safeguarding professionals will need to have significant geographical and population coverage. This may not be the case if CCGs cover a small population. It is unclear how much the designated role will be prioritised by CCGs in developing lead commissioning arrangements. We have concerns that if CCGs were made solely responsible for commissioning designated professionals’ roles the funding per CCG would be inadequate to commission all of a designated professional’s time, potentially resulting in fragmentation of the system. Where designated functions are shared across a number of CCG’s there is a risk that influence will be diluted. For example, a CCG which allows another CCG to commission designated professionals on behalf of them in order to cover a sufficiently large area, may be less engaged with those professionals than the lead commissioner. The ADCS survey of LSCBs showed that 55% of boards thought that designated professionals within the health service should be commissioned jointly between local authorities and the NHS through health and wellbeing board structures.

— The NHS Confederation supports the ADCS survey findings and recommends that safeguarding professionals within the health service should be jointly commissioned by clinical commissioning groups and local authorities using mechanisms such as Section 75. A joint commissioning arrangement should not diminish CCG responsibilities for commissioning safeguarding professionals and integrating safeguarding within all commissioning decisions. Named and designated safeguarding professionals will continue to be hosted and employed by NHS organisations.

4.4 As structures develop following the health reforms our members have expressed concern that the number of designated posts may reduce. The ADCS survey shows that designated nurses and Looked After Children (LAC) posts have slightly decreased but posts for designated doctors have increased slightly. There has been a 22.5% increase in vacancy rates for safeguarding nurses and 65% increase in vacancy rates for designated LAC leads since 2010. 33% of the ADCS survey LSCB respondents felt that these vacancies reduced the effectiveness of support for Local Safeguarding Children’s Board.

— The survey’s findings demonstrate there is a need to ensure safeguarding professional levels are actively monitored and maintained during the health reforms transition by the Department of Health.

4.5 In some areas, clinical commissioning groups may have a different geographical footprint to the local authority and therefore the health and wellbeing board and Local Safeguarding Children’s Boards. This will make it difficult for CCGs to commission on a population-wide basis in collaboration with local authority colleagues. We recommend:

— clinical commissioning group boundaries should have a rational relationship with local authorities for both planning and public health purposes. This is proposed by the Government following the pause in the passage of the Health and Social Care Bill 2011 through parliament earlier this year.

— if a CCG overlaps with more than one local authority boundary, clear mechanisms will be required regarding how they will work with the LSCB and local authority bodies. The NHS Commissioning Board could take on a coordinating role to ensure that CCGs are charged with coming together to take decisions that impact on populations that are greater than the areas they service and work with other areas to ensure continuous provision of care.

4.6 We are concerned that there is very limited reference to safeguarding in the NHS and public health reforms. As public health responsibilities transfer to local government there is an opportunity to join up public health efforts more with local authorities and the health service to strengthen prevention and early intervention. We continue to argue that support provided by children’s and adult’s services needs to be co-ordinated and focused on problems affecting the whole family. This reinforces the importance of adult services being commissioned and provided with consideration of the needs of dependant, vulnerable children. The positive impact of good safeguarding arrangements on adult issues such as domestic violence, mental health and substance misuse is clear. We recommend that:

— safeguarding, including child protection, prevention and early intervention should be a key responsibility for the new public health system, including Public Health England; and

— there are clear links between the work of Public Health England and public health teams within local authorities and safeguarding professionals that sit within the health services.

October 2011

169 69 out of 151 Local Safeguarding Children’s Boards responded to the survey.
Written evidence submitted by Association of Lawyers for Children

The Association of Lawyers for Children (“ALC”) is a national association of lawyers working in the field of children law. It has over 1200 members, mainly solicitors and family law barristers who represent children, parents and other adult parties, or local authorities. Other legal practitioners and academics are also members. Its Executive Committee members are drawn from a wide range of experienced practitioners practising in different areas of the country. Several leading members are specialists with over 20 years experience in children law, including local government legal services. Many have written books and articles and lectured about aspects of children’s law, and several hold judicial office.

The ALC exists to promote access to justice for children and young people within the legal system in England and Wales in the following ways:

(i) lobbying in favour of establishing properly funded legal mechanisms to enable all children and young people to have access to justice;
(ii) lobbying against the diminution of such mechanisms;
(iii) providing high quality legal training, focusing on the needs of lawyers and non-lawyers concerned with cases relating to the rights, welfare, health and development of children;
(iv) providing a forum for the exchange of information and views involving the development of the law in relation to children and young people; and
(v) being a reference point for members of the profession, Governmental organisations and pressure groups interested in children law and practice.

The ALC is automatically a stakeholder in respect of all government consultations pertaining to law and practice in the field of children law.

The Education Select Committee seeks responses to the following questions about the child protection system in England:

1. Whether the child protection system allows for the effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation);
2. Factors affecting the quality of decision-making in referral and assessment, and variations across the country;
3. Appropriate thresholds for intervention, including arguments for and against removing children from their families;
4. Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child.

These questions are very broad, and some aspects are outside our expertise. We therefore intend to offer a brief summary of our views on some key points. We also attach our detailed response to the Family Justice Review Interim Report (dated 22 June 2011), much of which we consider is pertinent to the Education Committee’s questions.

The Committee will clearly be assisted by the findings and conclusions of the Munro Review. In addition we suggest that the Justice Committee’s report “The Operation of the Family Courts” (HC 518–1, July 2011) and the Care Profiling Study (Professor Judith Masson, the Ministry of Justice (2008)), are also highly relevant to aspects of the questions posed.

Q1. The ALC membership usually engages with the child protection system when the child is the subject of care proceedings or adoption proceedings. The ambit of some of the Committee’s questions is much wider and covers all children in need of support and assistance from social services. In March 2010 over 380,000 children were classified by local authorities as “children in need” for the purposes of duties imposed on them by section 17 of the Children Act (1989). The population of children in care or “looked after” by local authorities was about 64,400 in the same year. Of these children, 60% came into care via legal proceedings and were subject to care orders (40%) or interim care orders (20%).

(D of E, 2010a, 2010b; Children Looked After by Local Authorities in England, year ending 31 March 2010). This population of children is judged to be at the gravest risk of abuse or neglect.

Our view is that our child protection system does not reliably provide for the early identification of, and early help to, children at risk of abuse and exploitation. The ALC endorses the findings of the Munro Review, and also the findings of Professor Masson’s Child Care Profiling Study (MoJ 2008). One highly significant fact is that, despite more than 90% of families often being “known” to local authorities for at least one year and 45% for more than five years before proceedings are commenced (Masson 2007), it is still the case that 40% of care cases still come to court without a core assessment having been completed. Early help to the child and his family also varies greatly from one local authority to another. Our experience is that help is too often short-term and spasmodic, in response to crisis, rather than sustained and planned. However, it is vanishingly rare for judges or lawyers to question the need for the issue of care proceedings. The question often asked is why they were not brought sooner.

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Q2. This question is essentially a question about national variations in social work practice and is outside our expertise. We again refer the Committee to the findings of Professors Munro and Masson on this issue.

Q3. This is a complex issue. In 2007, the findings of the Commission for Social Care Inspection were that the threshold for intervention by some local authorities was dangerously high:

"Access to family support for many families in need is severely restricted. Families in considerable distress on the threshold of family breakdown and serious harm are not getting the sustained support they need. Some services operate inappropriately high thresholds in responding to child protection concerns and taking action to protect children . . ." (CSCI March 2007).

Thresholds of harm which trigger local authority intervention in family life also vary from one local authority to another, for no obvious reason. Thresholds for intervention can also vary due to factors and incentives that have little to do with objectively ascertainable harm or risk to a child. Examples from the last five years include: annual public service agreement targets set for local authorities by the former government to reduce the number of children in care or subject to a child protection plan; increasing the court issue fees for local authorities taking care proceedings from less than £200 to a maximum of £5,000; and the introduction of a new court procedure ("the Public Law Outline" or PLO) which placed fresh burdens on local authorities with which they were largely unable to comply (Masson 2008). The twin impacts of the introduction of the issue fee increase and the PLO in April and May 2008 brought about a nationwide reduction in the number of applications for care orders of approximately 30%.

The subsequent publicity surrounding the Baby Peter case caused a reversal of this sharp downturn, and there was a surge in the number of applications for care orders. This increase restored the number of applications to the pre-2008 levels. It is noteworthy that in 2009–10, the number of children’s guardians appointed in new care cases (8,614) was very similar to the number appointed in 1998 (8,900). (These figures are drawn from the CAFCASS Annual Report July 2010, and from the government’s consultation paper “Support Services in Family Proceedings: Future Organisation of Court Welfare Services” DoH, Home Office and Lord Chancellor’s Department, July 1998, paragraph 5.1.)

Although the number of applications for care orders continues to rise, there is no evidence that care proceedings are being brought unnecessarily or that local authorities are operating thresholds for intervention which are too low. The wide formulation of significant harm in section 31(9) of the Children Act 1989 is still arguably being too narrowly applied by many local authorities. Care proceedings permit an evidence-based approach where the best social work and clinical evidence is brought together before a specialist care court. The definition of significant harm also changes and evolves as our knowledge of child development and clinical research improves our understanding of children and the impact of their upbringing. The long-term effects on children of witnessing domestic violence are a classic example of this evolution.

Q4. This is a very wide question and, save insofar as it applies to the legal system for children at risk, lies outside our expertise. In brief, we do not think that the legal system is working as well or as efficiently as it could. We support many, but not all, of the reforms proposed by the Family Justice Review. Furthermore, we have grave concerns about the impact of the proposed further cuts to legal aid for vulnerable children and their families, which will cause deterioration in standards of representation, reduced availability of experienced child and family practitioners, and consequently greater delays in the courts.

Children need to be protected from harm, but they and their parents also need to be protected from improper interference in family life by public authorities. Local authorities make mistakes. Poor social work practice can produce weak and flawed assessments. Local authorities need to protect departmental resources and reputations and this too can lead to poor planning for individual children. The specialist care judges, children’s guardians, and lawyers help to ensure that there is a well-informed focus on the interests of the individual child in each case. They are an important part of the child protection system.

We also have serious and longstanding concerns about the decline in the guardian service for children in care proceedings provided by the Children and Family Courts Advisory and Support Service (Cafcass). In its recent report "The Operation of the Family Courts" the House of Commons Justice Committee found that "The entire family justice system should be focused on the best interests of the child. CAFCASS as an organisation is not." (HC 518–1, 14 July 2011, paragraph 199).

Our particular concerns centre on the lack of organisational support in Cafcass for the independence of the children’s guardian, who is appointed by the court to represent the child in all public law proceedings. The children’s guardian is the best safeguard against poor social work, and also ensures that the voice of the child is heard in court proceedings, where the interests of local authorities and parents can predominate. There also continues to be significant pressure on guardians to reduce the amount of time they spend talking to or observing children. One of the significant findings quoted in the Munro review was that social workers did not spend enough time with children who were subsequently the subject of serious case reviews (Munro, chapter 2, page 25, paragraph 2.5). We can ill afford to duplicate that failing in a service which represents the individual interests of children who are at the gravest risk of harm.

**October 2011**
Written evidence submitted by The Children’s Society

1. THE CHILDREN’S SOCIETY

1.1 The Children’s Society supports nearly 50,000 children and young people every year through our specialist services and children’s centres. We believe in achieving a better childhood for every child but have a particular focus on vulnerable children who have nowhere else to turn. We seek to give a voice to children and young people and influence policy and practice so they have a better chance in life.

2. SUMMARY OF RESPONSE

2.1 The Children’s Society welcomes the Select Committee’s Inquiry into the child protection system in England. Our submission focuses on the safeguarding responses to vulnerable young people aged 11–17 years old. The evidence included in this submission is taken from our experience of providing services to young people and from our recent research into safeguarding young people who are maltreated. The research provides new evidence to what has been an under-researched area of safeguarding vulnerable teenagers.

2.2 This response sets out evidence relating to:

— The child protection system does not currently enable children to receive early intervention support as the thresholds are too high.
— Young people are not being identified as at risk by professionals and are often perceived as more resilient or able to cope with situations compared to younger children.
— Young people are less likely to receive a children protection response from Children’s Social Care, they are more likely to receive an assessment through a “child in need” referral or through the Common Assessment Framework (CAF).
— There is a lack of specialist early intervention services for vulnerable teenagers.
— Universal services have a vital role in identifying young people in need of additional support, however there is a lack of training and awareness amongst professionals of the specific needs of older young people.
— There are differences in response between and within different Children’s Social Care services to young people aged 11–17 years old who have been maltreated.
— A barrier to professionals making a referral to Children’s Social Care is the perception that thresholds and resource constraints would mean they were unable to respond.

2.3 Recommendations

— The Government should place a duty on local authorities and statutory partners to secure the sufficient provision of local early help services for children, young people and families.
— The new inspection framework should inspect Children’s Social Care on what early intervention services they provide for vulnerable teenagers.
— Every professional who works with children should be trained to identify safeguarding issues and be clear about how to refer concerns to Children’s Social Care.
— Running away must be recognised as an early indication that a child is at risk. This should be seen explicitly as a child protection issue by all Local Safeguarding Children’s Board’s with protocols and procedures in place backed up by clear systems of accountability and performance management.
— Clear accessible information about the safeguarding process should be made available to all young people who come into contact with Children’s Social Care. The child protection system should actively facilitate young people to seek help and ensure that services are provided to support them directly.
— Young people should be listened to and their views taken into account within the child protection process to ensure that their needs are met.
— The government needs to carefully monitor the timeliness of decision making by Children’s Social Care to ensure that cases are not left to drift without a decision being made.

3. EARLY IDENTIFICATION AND EARLY HELP

3.1 Our experience is that due to high thresholds operated by many Children’s Social Care services, the current child protection system does not enable children to receive early intervention support. The cases that are responded to are mainly children in crisis situations, or who have complex and acute needs.

3.2 We are concerned about the children who do not meet the current thresholds for Children’s Social Care interventions. For this group, consideration should be given regarding how the voluntary sector and universal

Notes:

170 Rees, G, Gorin, Jobe, A, Stein, M, Medforth, R & Goswami, H (2010). Safeguarding young people: Responding to young people aged 11 to 17 who are maltreated. London: The Children’s Society. The research was undertaken in partnership with NSPCC and the University of York. 160 interviews with professionals were carried out with 12 local authority areas including social workers, police, teachers and voluntary sector. In addition, a detailed practice study was conducted in four Children’s Social Care services.
services work with Children’s Social Care to support the safeguarding process. The Children’s Society fully
supported Professor Eileen Munro’s recommendation that there should be a statutory duty on local authorities
and their partners to commission services that offer early help to children and their families. The new
inspection framework should not focus solely on what support children in the child protection system are
receiving, but also on the response to those on the “edge” of the system.

3.3 Our research shows that young people are often not identified as being at risk by professionals, and are
often perceived as being more resilient and able to cope with the effects of abuse, more able to remove
themselves from abusive situations and more likely to disclose abuse than younger children. Our projects have
shared how young people’s views are not being taken seriously by professionals and that the information they
share is not taken at face value. We know from research that as children get older they are less likely to receive
a child protection response from Children’s Social Care services. Instead they are more likely to receive other
responses to meet their needs such as a “child in need” assessment or the CAF.

3.4 To ensure that children are identified for early help, universal services such as education and health have
a key role to play—both in raising awareness amongst children about how to get help and ensuring that every
professional who works with children is trained to identify safeguarding issues and be clear about how to refer
careers to Children’s Social Care.

3.5 Due to cuts to public services, a number of specialist support projects are currently experiencing
reductions in their funding or have their funding at risk over the next financial year. A recent report has
identified that services for young people have lost a quarter of their funding during 2010–11.

3.6 A recent analysis by The Children’s Society into the cost and potential savings of early interventions
with children who run away from home, has found that investing in early intervention results in net savings to
public services and wider society ranging from £2,000 for less severe cases to potentially £300,000 or more
for children entering the looked after system, or those that have committed crime. The report estimates that
the current cost to police, public services and society is up to £82 million every year; this is a conservative
estimate with the potential costs being much greater.

4. FACTORS AFFECTING DECISION MAKING IN REFERRAL AND ASSESSMENT

4.1 Our practitioners have highlighted that in some areas of the country, Children’s Social Care are using
deflection strategies at the point of referral to reduce the amount of cases being accepted. These will include
“strategic deferment”, where the referral will be sent back to the referrer to ask for more information about
the case and “signposting” where the case will be referred to a more “appropriate” agency or response for the
young person. In areas where the CAF is embedded, agencies will be asked whether this has been completed,
and whether it has been completed properly, before undertaking an initial assessment.

4.2 Due to the requirement for assessments to be conducted within set timescales, this has led to many areas
employing staff to take referrals who are not qualified social workers or to have a central call centre for
referrals. As a result of the pressure on social work teams to make these decisions quickly, in many areas of
the country quick decisions have been made about cases rather than undertaking quality assessments. Social
workers need time to speak to children, understand the complexities of family situations and be able to receive
information from agencies who are involved with those families to make an informed decision about the child’s
environment and risks faced by them. There should be a balanced approach between providing social workers
with time to undertake quality assessments and the need for a timely response to a child, to ensure that we do
not return cases drifting without a response.

4.3 Young people were also more likely to be seen by professionals as contributing and exacerbating their
situation through their own behaviour. The research highlights a change in perception of professionals from
considering of younger children being “at risk” and older young people “putting themselves” in risky
situations. Our research has found that there is no difference in the likelihood of an older young person being
referred to Children’s Social Care than younger child after an assessment of risk. However, initial perceptions
of risk by professionals were found to be affected by age, for example professionals were less likely to refer
young people as a result of supervisory neglect and emotional abuse. This uncertainty around assessment is
further complicated by older young people being more likely to be at risk from situations outside the family,
for example substance misuse and sexual exploitation.

5. APPROPRIATE THRESHOLDS FOR INTERVENTION

5.1 Despite the Government definition on maltreatment being clearly set out in guidance, our research
highlighted concerns about the different thresholds operated by Children’s Social Care in local areas. Many

Education.
172 National Council for Voluntary Youth Services (2011) “Comprehensive Cuts 3: where are we now for young people and the
referring professionals thought that these were determined by to the availability of resources rather than an assessment of the needs of the child. For many professionals this deterred them from making a referral as they did not feel it would be acted on. Additionally, for professionals working across a number of local authorities with differing thresholds, such as the police, this added further complexity to the referral process.

5.2 Professionals perceived Children’s Social Care services as being less likely to take action in cases involving older young people, particularly for young people aged 15 years and over. Issues around defining and prosecuting cases of neglect and emotional abuse were highlighted as the most problematic in terms of identifying whether or not they would meet local authority thresholds. Research suggests that referrals are typically triggered by an event, or other concern such as sexual or physical abuse, rather than on-going concerns about neglect.

5.3 The case histories of young people aged between 11–17 years old tended to be more distinct and complex than those of younger children. This is because their own behaviour became a part of the assessment, including factors such as substance misuse or risk taking behaviour. Professionals highlighted uncertainty about making a referral for particular situations including young people having sexual relationships with older males, two-way violence between young people and parents and when young people have been thrown out of home and the parents do not want to be part of the child protection process.

5.4 The research highlighted concerns raised by referring professionals about what to do in a situation where parents are reluctant to keep children within the family home. Professionals identified a number of possible alternative responses such as monitoring the situation, providing direct services and working with other agencies, that they might suggest in cases where they had made a decision not to make a referral to Children’s Social Care services. They identified that the child protection system can be inappropriate when the parent does not want their child at home and young people do not want to refer themselves for help. Professionals reported Children’s Social Care services as using a risk management approach to working with young people rather than a child protection approach.

5.5 Challenges identified by professionals in safeguarding young people aged 11–17 years old include:

- resource and capacity issues of Children’s Social Care to respond;
- information sharing between different agencies and a clear consistency of thresholds for intervention across agencies;
- the need for training and accessible support for professionals in a range of settings; and
- working with parents to enhance their parenting skills.

6. CHILD PROTECTION POLICIES AND PRACTICE OF NON-SOCIAL WORK AGENCIES

6.1 Non-social work agencies such as the police, education and health services have an important role to play in identifying children at risk, and making the necessary referrals into Children’s Social Care. A child may demonstrate a number of risk indicators and behaviors—for example missing education, running away from home and committing crime—that would make them come into contact with non-social work agencies. Local Safeguarding Children’s Boards should lead this process locally and set out protocols and procedures for all agencies, clearly defining roles and responsibilities for responding to safeguarding concerns. These protocols should contain clear procedures for recording and sharing information between professionals to ensure a joined up response.

6.2 In supporting children to make disclosures, all agencies should receive training about how to work with young people in an effective way. Our research found that many young people were deterred from making a disclosure due to the professional’s attitude, or the fact that they were unclear about the role of a professional. For example, for every child who runs away, on their return the police are responsible for conducting a “safe and well” check. This intervention can identify issues of significant harm, such as violence at home, or the young person being a victim of crime. However, these are not completed effectively in every area, nor is the information shared with Children’s Social Care services to inform assessments for that child. In addition the child should receive an independent return interview from a person the child trusts.

6.3 The importance of the voluntary sector in local areas has been highlighted as a key factor in safeguarding children. These projects are able to provide independent and confidential advice and support for children and their families. The flexible and accessible approach offered by these services is valued by statutory agencies and children due to the ability to provide them with immediate support. Children and young people are often reluctant to share information with the police or social workers due to fear of statutory agencies. The voluntary sector workers are able to build trusted relationship with children to enable them to share information. Projects also provide access to a range of other services including substance misuse support, family mediation and parenting work. They will have an important role in sharing information with statutory agencies to safeguard and engage children to develop a support package to meet their needs.

7. CHILDREN’S VOICES AND PARTICIPATION

7.1 It is important to consider young people’s experiences of the referrals process and that these form part of the assessment. In the research many young people highlighted the need to build trust and relationships with
8. DISABLED CHILDREN AND YOUNG PEOPLE

8.1 In relation to our work with disabled children, research indicates that this group faces an increased risk of abuse or neglect yet they are under-represented in safeguarding systems. Disabled children can be abused or neglected in ways that other children cannot and the early indicators of whether a child has been abused or neglected can be more complicated to identify than with non-disabled children. Behaviours indicative of abuse such as self-harm and repetitive behaviours may be misconstrued as part of a child’s impairment or health condition. It is vital that professionals are adequately trained and able to identify and recognise indicators of potential abuse or changes in children’s behaviour.

8.2 Attitudes about disability are also contributory factors in the lack of reporting of abuse to disabled children. Estimates suggest that only one in thirty cases of sexual abuse of disabled people is reported compared to one in five in the non-disabled populations.

9. REFUGEE AND MIGRANT CHILDREN

9.1 The Children’s Society would also like to highlight our concerns around particular child protection risks that refugee and migrant children are exposed to. Our key concerns relate to; the lack of effective implementation of the UK Border Agency’s Section 55 duty to safeguard and promote the welfare of children; the serious risks posed to children whose age is wrongly assessed and mistreated as adults (including detention and destitution); and the risks posed to non-UK born children at risk of exploitation and abuse in private fostering arrangements. Separated migrant children, including victims of trafficking, still experience considerable disadvantages as the policy responsibility for this area of work does not come under the remit of the Department for Education. However, refugee and migrant children should be treated as children first and foremost to ensure their safety and wellbeing is guaranteed.

October 2011

Written evidence submitted by Designated Professionals Network

1. EXECUTIVE SUMMARY

“The aim is to make it harder for people to do something wrong, and easier for them to do it right”.

1.1 In this paper we suggest the following:

— ideas intended to produce greater levels of competence in the healthcare workforce;
— the removal of legislative hurdles to good safeguarding practice;
— the need for support for child safeguarding in the current period of change in the NHS;
— changes in safeguarding practice to hear the voice of the child and to take into account the reality of significant health conditions that are causes of concern;
— information governance changes to remove barriers to information sharing; and
— the introduction of a Child Impact Assessment process for both legislative and executive state functions.

2. INTRODUCTION

2.1 The Designated Professionals Network is the collective of all the Designated Doctors and Designated Nurses who work in London. As the strategic, professional leads for Child Safeguarding, we provide professional advice and support to our respective Local Authority Public Health Teams, Provider Organisations,
Local Safeguarding Children Boards, GP lead Commissioning Consortia, and the NHS Commissioning Board. We stand by the following Child Safeguarding priorities:

- Paramourcy of the needs of the child.
- Listening to the voice of the child.
- The maintenance of a robust statutory NHS safeguarding structure.
- Improving training and awareness.
- Continuing development of child safeguarding systems.
- Continuing development of child safeguarding accountability.
- The maintenance of designated professional leadership in order to advise commissioners, safeguarding boards, health and well-being boards, health providers and academics institutions at the correct level.
- The fulfillment and extension of statutory responsibilities of child safeguarding.

2.2 In submitting this paper, we address the four points that have been raised in the call for evidence. They are:

1. Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation);
2. Factors affecting the quality of decision-making in referral and assessment, and variations across the country;
3. Appropriate thresholds for intervention, including arguments for and against removing children from their families;
4. Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child.

3. EVIDENCE

3.1 Background

3.2 At the heart of child safeguarding, is a child who’s care or parenting needs have either partially or completely failed, or worse, have been replaced by significant malign influences.

3.3 The appropriate response is to restore good care and parenting, or replace the deficiencies. In many child safeguarding situations, health services play a significant part in this process. The legislative framework for children requires us to not only make the well being of the child our paramount consideration, but also to cooperate with other agencies to improve the well-being of children.

3.4 Issue 1: Early identification and early help

3.4.1 Training and competence

3.4.2 Healthcare professionals need to have the appropriate competences (a competence is defined by it’s three component parts: knowledge skills and attitude) to identify risks and follow the most appropriate corrective pathway. There is also a need for robust safeguarding leadership. This is not least because healthcare professionals play an important role in identifying safeguarding needs of all children under the age of 18 and particularly those below the age of five, and the very real support and supervision needs of families. This requires good leadership to enable the confidence and competence of practitioners to develop.

These leadership competences should be part of the development of a child safeguarding career, which would be greatly supported by governmental recognition of the need for such a career pathway.

The appropriate competences required have been drawn up in the Intercollegiate document 2010 (4h). All those who work in healthcare are required to receive appropriate training and updating. It is our experience that it is possible to achieve satisfactory levels of attendance at training courses. However there is no requirement on any trainee to demonstrate the necessary learning from such training. This contrasts markedly with the rigorous examination system in place for healthcare professionals that is applied to all other areas of their work. It is our view that training should be followed by a rigorous professional assessment. A number of obvious benefits would arise from this, including greater reliability of safeguarding children service delivery and an increased self-confidence in healthcare practitioners to tackle child safeguarding with the professionalism that such an important part of our community deserves.

3.4.3 Conflicting legislation

3.4.4 The importance of family integrity to a child is a fundamental principle in child safeguarding. Keeping a child and its family together particularly in the early stages of a child’s life, is not just socially desirable but also a physiological necessity. There is also a legislative requirement for practitioners to safeguard all
children of whatever background. For some deprived families, (for example, economic migrants from accession states within the EU), who have no access to public funds for their first twelve months in the UK, appropriate efforts to maintain family cohesion around a seriously sick child can on occasions become quite overwhelming. Such efforts distract professionals from the main task of improving the well-being of the child and can become quite demotivating. It is our experience that our partners in social care, whilst recognizing the need to support families in such situations, can feel at some jeopardy if they attempt to fund destitute families from public resources who in law deserve no such favours. If the principle of paramancy or the interests of the child is to mean anything this risk should be mitigated by legislation.

3.5 Issue 2: Decision-making in referral and assessment

As we all work in London, we are unable to offer comments about variations across the country, but offer the following.

3.5.1 Child safeguarding and commissioning

3.5.2 The quality of decision-making depends not only on the analytical capacity of the partners involved in referral and assessment, but critically on the quality of information which is provided. As a lot safeguarding information derives from healthcare, it is pivotal that child safeguarding is at the heart of all health services commissioning and is thereby well integrated into the working of all health professionals. It is our experience that whilst healthcare services which concentrate on service provision to children usually have an awareness and an understanding of child safeguarding procedures, many other parts of healthcare are not yet fully integrated into the child safeguarding agenda. This has particular significance for the large workforce deployed in adult mental health, including drug treatment programs, whose patients potentially represent welfare risks to the children in their care. We are concerned that during the changes currently being implemented in the health service, any lack of ambition to keep child safeguarding paramount and healthcare practitioners involvement and awareness as a top priority will at best produce stagnation and at worst a decline in capacity and competence. We already have evidence of strategic leads such as ourselves (Designated Professionals) being lost to the service. By the same token conflation of roles for named professionals is being seen: in some cases named colleagues are being called upon to undertake both acute and community duties. In others they are required combine child safeguarding with adult safeguarding responsibilities. In either event, this is leading to loss of operational expertise amongst providers. We believe this is a result of a lack of understanding of the designated and named safeguarding children roles, as well as a lack of insight into the legislative injunction on us to make the welfare of children our paramount concern.

3.5.3 Effective partnership working with social care

3.5.4 With pressures on our social care partners causing them to do “things right” rather than “doing the right thing” (8) there has been an increasing tendency for health and social care to work across an increasingly large divide. This is particularly relevant for general practice colleagues, who being universal service providers, have a lot to offer but whose engagement has historically become disturbingly remote. So rather than effective multiagency working with an emphasis on local networks and communication, too often there has been a sense of “them and us” held on both sides of the divide. Social care had been isolated by being seen as those that take decisions and general practice has been isolated by being seen as too busy to be involved. As a consequence important sharing of information has often been minimised.

3.5.5 This has particular meaning to the more interpretive work that healthcare professionals have to do in explaining the significance of medical findings and medical conditions to their social care partners. This applies not only for the causality of injuries found in non-accidental injury cases and child sexual abuse, but also in the more complex areas of the medical findings of neglect and the sometimes insuperable complexity of factitious or induced illness.

3.5.6 There is therefore very real need for both sides of the divide to recognize this weakness and to be encouraged and supported to bridge this communication divide. This has particular applicability to the issue of thresholds.

3.6 Issue 3: Thresholds and child removal

3.6.1 Relapsing and remitting conditions

3.6.2 It is entirely appropriate for the state to have thresholds below which it will not intervene in a family’s life; there are many areas, particularly in the early intervention programs, where only support rather than intervention is required and that for only a limited period. However in matters of health intervention, many of the risks to child well-being, (for example parental mental illness, parental drug and alcohol dependence, and chronic medical conditions for both adult and child), the concept of a threshold for intervention does not fit with the relapsing and remitting nature of these particular circumstances. Within the health economy, it is clearly understood that adults with chronic mental or physical illness will have periods of good health and bad, and which will alternate throughout the childhood of their offspring. The child safeguarding system with fixed thresholds will deal with the acute episode. However once that is dealt with, social care will be inclined to withdraw from any involvement, whereas healthcare practitioners will be watching for signs of change that
3.6.3 Information sharing

3.6.4 There is a persisting sense in healthcare that for a lot of families, general practitioners in particular are sitting and waiting for familial bombs to explode. This isolating position is not good for the necessary sense of diligence that is required for child safeguarding, and flies in the face of the fundamental tenet of multiagency practice and shared decision-making. One way of resolving this problem would be the establishment of a local repository of risk information that would conform with the best practice of communication management, and act as a hub for information sharing. Given the prevalence of failures of information sharing in child safeguarding tragedies, we believe such a structural modification to the process is worth investigating.

3.6.5 Maintaining family trust

3.6.6 The biggest challenge for frontline healthcare workers involved in child safeguarding assessments is to keep families of concern involved in an effective working relationship with the health economy. This is particularly important in general practice where many healthcare practitioner/family relationships have been built up over years, or decades. The concept of a referral to the social services in the minds of many patients is inextricably linked with the removal of children. This raises anxiety within the family that can be as much a source of safeguarding concern as the original issues. Whilst there is plenty of evidence that removing children from severely dysfunctional families can have a positive outcome for the child, this is by no means always the case. The safeguarding team knows what is needed in terms of support and healthier family behaviour. Achieving that outcome, however, can seem nigh on impossible and certainly not painless. It is as though child safeguarding is at the same stage of development that surgery was before anaesthetics were invented: we know what we need to do to save patients life but with our current set of skills and knowledge we know it’s going to hurt and may do more harm than good.

3.6.7 There is a need to consider the solution as a cultural change regarding child upbringing and improvement of well-being. The establishment of the idea of children being a communal responsibility rather than being parental property would surely help, and would be a reflection of the standard model of health care of trust and support for all other medical conditions.

3.7 Issue 4: Non social work policies and practices

3.7.1 There are a number of substantial issues which prevent the child protection and child safeguarding pathway matching the needs of the child. Some of these have been mentioned already. Others include:

3.7.2 Confidentiality issues

3.7.3 The health economy, in common with all the other agencies that deal with children, has high professional standards with regards to identifiable personal information. The Caldicott principles underpin the NHS approach to management information and are held in high regard. These principles however conflict with the essential principle of effective multiagency child safeguarding of information sharing. Within health this has led to a persistent anxiety amongst healthcare practitioners which has undoubtedly acted as a disincentive to consider and act on all concerns or suspicions. It is right and reasonable that patient information should be safeguarded for regular clinical care. However this principle is applied to maintain personal dignity and privacy, issues which do not compare with the risk of failing to prevent significant harm to a child. A helpful alternative would be the development of a circle of confidentiality around the team of professionals involved in safeguarding enquiries and intervention, so that within this group information about all personal issues can be freely shared without personal jeopardy to the professionals involved. This change would make it easier for professionals to share information fully and completely, and thereby enhance the standard of safeguarding of the children involved.

3.7.4 The child’s view as a key performance indicator

3.7.5 A large number of measures are used to evaluate the effectiveness of child safeguarding. Repeated failures of the system particularly within health, serve only to emphasise lack of involvement of children in their own destinies. This is regrettable and has been referred to time and again as a worthy objective, but technical difficulties around interpreting children’s expressions particularly when they are very young makes this at best a hazardous exercise. Apart from this being a rather uncivilized way of behaving, this also breaches the United Nations Convention on the Rights of the Child (articles 9 and 12). We would suggest that greater efforts be made to inculcate this into child safeguarding processes as a matter of priority.
3.7.6 The lack of child paramountcy in government

3.7.7 Those in Child Safeguarding have to work under a statutory obligation to cooperate to improve the well being of the child and to keep the child’s needs paramount at all times. It seems to us that if the well being of children is required to be the paramount consideration of a local community, then the offices of State should be required to do the same. If her Majesty’s government were to put child safeguarding at the heart of its work, it seems self-evident to us that the risk of legislative conflict and the culture of children’s well-being in this country (generally acknowledged to be one of the poorest performers in Europe) could be significantly improved.

3.7.8 We therefore suggest the development of a Child Impact Assessment process with the paramountcy of the needs of children as it’s core philosophy. Such a process could require all proposed legislation to be evaluated for its compliance with the needs of children. The same process could also be applied to the work of national, regional and local institutions to ensure that the needs of children, and promotion of their wellbeing are given the paramountcy they are entitled to.

4. Recommendations

(1) The obligatory testing and validation of all child safeguarding trainees.
(2) The removal of legislative conflicts that impact of Child Safeguarding.
(3) The placing of child safeguarding principles at the heart of all health commissioning.
(4) The development of a ring of confidentiality around each multi-agency child safeguarding team.
(5) The development of local child safeguarding information hubs.
(6) The development of a continuing social care interest in families with relapsing and remitting safeguarding challenges.
(7) The development of the views of the child as a key performance indicator.
(8) The development of a legislative and executive Childs Needs Assessment process.
(9) The strengthening of the NHS safeguarding children structure by the development of a career pathway that recognizes the specialist skills of NHS named and designated professionals.

References

(1) To err is human: Building a safer healthcare system. The Institute of Medicine 1999.
(2) Working Together to Safeguard Children DCSF 2010
(3) The Children Act 1989
(4) The Children Act 2004
(5) Safeguarding Children and Young People: roles and competences for health staff. The Intercollegiate Document. Royal College of Paediatrics and Child Health and partners, 2010
October 2011

Written evidence submitted by End Violence Against Women

1. Summary

We warmly welcome the Education Committee’s Inquiry into the Child Protection System in England. As a coalition of experts on gender-based violence against girls and women we believe that the Child Protection System plays a fundamental role in protecting girls and preventing abuse. However we are very concerned that key public authorities may not be complying with their legal obligations. In particular, we believe that the education system is failing to ensure girls’ safety and to provide support in the event of abuse. For example, in November 2010 we published a YouGov poll showing that nearly one in three 16–18 year old girls have experienced unwanted sexual touching at school in the UK.

We have long campaigned for strategic approaches as the only effective way to tackle this issue and welcome the Home Office’s strategic narrative, Call to End Violence Against Women and Girls, which was published in November 2010 followed by an Action Plan in March 2011. In her introduction, the Home Secretary says:
“We will work across the whole of government on preventative measures to stop violence from happening in the first place.” Unfortunately, failings in the Child Protection System are undermining this objective.

We endorse submissions and recommendations to the Inquiry from expert members of our Prevention Network; Imkaan, FORWARD, South Essex Rape and Incest Crisis Centre (SERICC), and Against Violence and Abuse (AVA).

2. ABOUT THE END VIOLENCE AGAINST WOMEN COALITION

The End Violence Against Women (EVAW) Coalition campaigns for governments and public bodies at all levels around the UK to take urgent action to eliminate all forms of violence against women and girls. We are the largest coalition of its kind in the UK representing over 7 million individuals and organisations. Our members’ expertise covers many years of grassroots experience working with victim/survivors within a wide range of settings, as well as second-tier organisations. A full list of our members is on our website: www.endviolenceagainstwomen.org.uk.

We are funded by Comic Relief to run the EVAW Prevention Network, a group of organisations with significant expertise on preventing all forms of violence against women and girls in England. We are linked into similar networks around the UK.

In June 2011 we set out a series of actions in our report, A Different World is Possible, for government, schools, local authorities and other key public bodies. These recommendations are set out at the end of these submissions. The report included an adapted model of Professor Carol Hagemann-White’s innovative “Model of factors at play in the perpetration of violence”. Alongside this we launched a report profiling 15 projects, including those working in schools, to tackle gender-based violence and abuse. On the same day we launched our short video, We Are Man, which is an example of a communications campaign to change boys’ attitudes to sexual violence and harassment. The video can be found at www.youtube.com/user/weareman2011.

3. GENDER-BASED VIOLENCE AGAINST GIRLS

Violence against girls is widespread, as are attitudes among young people that normalise and excuse this violence as the following statistics indicate:

— Almost one in three girls have experienced unwanted sexual touching at school.175
— One in three teenage girls who have had some kind of relationship experience has experienced sexual violence from a partner.176
— It is estimated over 24,000 girls under 15 are at high risk of female genital mutilation (FGM) in England and Wales each year.177
— In 2010 the Forced Marriage Unit received over 1,735 calls to its helpline on suspected/potential forced marriage—86% were from women.178
— 77% of young people feel they do not have enough information and support to deal with physical or sexual violence.179
— Over 50% of girls and just over 25% of boys from disadvantaged backgrounds report being a victim of physical violence in at least one of their relationships.180
— 43% of teenage girls believe that it is acceptable for a boyfriend to be aggressive towards his partner.181
— One in two boys and one in three girls believe that there are some circumstances when it is okay to hit a woman or force her to have sex.182

4. EQUALITY AND HUMAN RIGHTS OBLIGATIONS TO PROTECT GIRLS

In addition to child protection and safeguarding policies, the government has obligations to prevent violence against women and girls under international and national human rights and equality laws. Under the UN Convention on the Rights of the Child, the UK has obligations to ensure that children are properly cared for and protected from violence, abuse and neglect by their parents, or anyone else who looks after them. Under the European Convention on Human Rights and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the UK has obligations to exercise due diligence in preventing

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175 End Violence Against Women and Yougov poll of 16–18 year olds (October 2010)
177 Dorkenoo et al., A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales Summary Report, FORWARD (2007).
181 NSPCC, Teen abuse survey of Great Britain (2005)
182 Zero Tolerance, Young People’s Attitudes to Sex, Violence and Relationships (1998)
violence against women before it happens. In Britain, the Public Sector Equality Duty under the Equality Act 2010 requires public bodies to take account of how they are promoting equality between women and men. Under the new duty, public bodies should be considering how they are preventing VAWG.

5. KEY ISSUES

5.1 Failures in the education system

Educational settings are a site of violence for young people—as our Yougov poll on unwanted sexual contact and sexual harassment in schools shows. It is also a place where attitudes can be shaped and gender stereotypes challenged. However many schools are failing to protect girls, provide support for pupils who experience abuse or violence, or to promote positive attitudes. In another study almost one in four 16–18-year-olds said that their teachers never said unwanted sexual touching, sharing of sexual pictures or sexual name calling were unacceptable.183

We welcome plans to include the teaching of sexual consent in the new PSHE guidance, however we believe that this is not just an issue for PSHE but a safeguarding issue, and that schools need to go much broader and address problems such as teenage relationship abuse, forced marriage, FGM, sexual exploitation and linked in to gender equality.

Communication between government departments is poor at present and we believe that a lead on violence against women and girls within the Department for Education (DfE) is critical and that the Department needs to engage with the Home Office’s VAWG Strategy substantially more than at present. For example DfE’s forthcoming Sexual Exploitation Action Plan (announced by Minister Tim Loughton in May) does not appear to be connected to this work. The Bailey Review on Sexualisation was similarly disconnected from the VAWG strategy and worryingly schools are absent from proposals to address sexualisation. Research suggests that the average age of first exposure to pornography for boys is much lower than 11 yrs old.184 Sex education in schools is a critical place for young people to learn about healthy relationships and sexual consent and to equip them to deal with the highly sexualised culture in which they are growing up.

5.2 Taking a Multi-agency approach, including community organisations

The experience of our members is that there is a need for a meaningful joined-up multi-agency approach. Appropriate intervention is more likely to take place if social services work consistently with the voluntary as well as other statutory agencies. However, the women’s voluntary sector services that also provide support is often cut out, only being contacted at crisis point. In addition, there are large gaps in knowledge of many professionals around all VAWG issues, especially harmful practices (forced marriage, female genital mutilation (FGM) and honour-based violence). The voluntary sector should be viewed as specialists with expertise that can be called on to strengthen statutory agencies’ work.

When multi-agency guidelines are not disseminated to professionals they are aimed at, as in the case of FGM, it is left to the voluntary sector to carry out essential training to equip professionals with the information and support they need in order to safeguard girls. In the experience of FORWARD there has not been any strategic work with communities in this regard. Schools are failing to safeguard female pupils by not working with affected communities.

A recent study found that there are contradictions and tensions between domestic violence, child protection and child contact as these three areas operate on separate “planets”185. The contradictions between them undermine children’s safeguarding. This means it is vital to bring these together in a cohesive, unified approach and closer working between professionals in each area is needed, as well as training to understand the links between the areas better.

5.3 Training

The experience of our members is that comprehensive and targeted training is vital for anyone likely to be dealing with VAWG issues, including teachers and social services. However, there is a lack of knowledge and understanding among frontline professionals and policy-makers, particularly on the more hidden forms of abuse, such as FGM. This leads to a poor understanding of risk factors and legal responsibilities, and not knowing how to respond appropriately when a case is picked up. For example, as AVA highlight, when a woman leaves a violent partner this can be an extremely dangerous time for her and her children. Professionals working with them need to be fully trained to understand the risks and how to best protect their safety, especially if child contact is ordered. Professionals may appear to place responsibility for leaving abusive relationships with the victim, rather than supporting non-abusing mothers to protect their children and themselves which is the most effective way to protect children. In SERICC’s experience women whose own history of childhood sexual abuse is known can often experience blaming and punitive interventions. Services in contact with these women need to be trained to provide appropriate support.

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183 End Violence Against Women and Yougov poll of 16–18 year olds (October 2010)
Training needs to equip professionals with the ability to identify risk factors, support children experiencing the abuse and act to prevent the abuse without further endangering them, and act in accordance with policies. Training needs to be ongoing throughout the professional career. We support AVA’s call for VAWG training to be a core module in all initial and ongoing training for professionals.

5.4 Data collection and analysis

Across all forms of violence and abuse of girls there is an inconsistent approach across agencies to data collection and analysis. This is particularly the case for violence in a specific cultural context such as forced marriage and FGM. As FORWARD point out, this means that professionals are often unaware that FGM is an issue in their area and therefore opportunities for protecting and safeguarding girls are missed. It also means that services are not planned adequately. Public bodies should be disaggregating data under their obligations under the Public Sector Equality Duty.

Disclosure is an issue across all forms of VAWG. SERICC have seen that common ways of dealing with disclosures of sexual and other forms of abuse can result in children being silenced, for example if they fear they might not be believed, or if they are told other people need to be involved. In Imkaan’s experience girls in gangs rarely disclose due to fear of reprisals and perceived limits to protection. The lack of data on the number of girls affected by gang violence means that girls at risk are ignored in policy and interventions and do not receive adequate protection. Statutory services are also not clear how they should respond to gang-related sexual violence.

5.5 Legal issues and immigration status

The Female Genital Mutilation Act 2003 applies only to UK citizens or permanent residents. It is not known how many girls at risk fall outside the protection of this legislation. Furthermore, as FORWARD point out, lack of certainty about the law means that professionals may be confused about what safeguarding levers and mechanisms are available to them. There have been no prosecutions and there is no comprehensive long-term strategy for tackling FGM.

5.6 Services

There is a need for more statutory services to support children and young people experiencing all forms of VAWG. The voluntary sector’s contribution should be as specialists who can work with statutory services. However, cuts to funding have meant that both statutory and voluntary agencies are finding themselves under threat.

6. Recommendations

Below we set out ten areas for action to prevent abuse of girls and women:

1. Develop and implement a cross-government gender equality strategy.
2. Ensure universal delivery of a “whole school approach” to prevent violence against women and girls across the primary and secondary education system.
3. Ensure funding for specialist violence against women and girls services to deliver prevention work.
4. Invest in research, monitoring and evaluation of prevention interventions.
5. Produce evidence-based and sustained public awareness campaigns.
6. Fund community mobilisation activities to challenge violence against women and girls.
7. Promote leadership at all levels to champion gender equality and non-violent norms.
8. Tackle the sexualisation of women and girls in the media and popular culture.
9. Commission the voluntary VAWG sector to deliver quality training on violence against women and girls to a range of agencies as part of vocational qualifications and ongoing professional development.
10. Target interventions to ensure prevention of violence against women and girls addresses intersections of gender with other social inequalities.

Our full recommendations for governments and public bodies:

Action by schools and academies:

- appoint VAWG champions amongst school governors and student councils;
- implement “whole-school” approaches on violence against women and girls, where the prevention of violence against women and girls is embedded into all aspects of school ethos, policy and practice;
- directly commission VAWG services to design and deliver targeted prevention interventions;
- ensure access for students to specialist VAWG support services in the community;
- ensure that their anti-bullying policies include an explicit reference to sexual harassment and bullying; and
— Under the Public Sector Equality Duty collect, analyse and publish data on students’ experiences and attitudes to VAWG.

Action by local authorities:
— establish local partnerships with relevant voluntary sector agencies, primary and secondary schools to support the coordinated delivery of prevention work;
— champion a “whole school approach” to preventing VAWG amongst primary and secondary schools, including academies, in their area; and
— Work with women’s groups to develop public campaigns to tackle attitudes.

Action by the Department for Education:
— amend the Education Bill 2011 to make it a requirement for all schools and academies to collect and report data on all forms of VAWG;
— communicate to all primary and secondary schools, including academies, the importance of addressing VAWG through a whole-school approach;
— appoint a senior policy lead who is responsible for developing and implementing a department-wide action plan on VAWG;
— work with organisations like the Centre for Excellence and Outcomes to ensure examples of best practice are disseminated widely across all schools;
— ensure initial and ongoing training for teaching and non-teaching school staff and governors to increase awareness and build skills to challenge VAWG;
— under the Public Sector Equality Duty, set an objective on tackling VAWG;
— develop specific strategies to ensure the safety and well-being of girls in Pupil Referral Units and consider alternative behaviour management strategies for girls;
— integrate gender stereotypes, sexualisation, VAWG and media literacy into the primary and secondary curriculum across all subjects in an age-appropriate manner as part of the National Curriculum review;
— make Sex and Relationship Education (SRE) and PSHE part of the statutory curriculum to ensure universal access for all students; and
— ensure the internal review of PSHE and SRE addresses VAWG. References on sexualisation, VAWG, healthy relationships, gender stereotypes, media literacy and the harms of pornography should be included in the Department’s guidance on SRE.

Ofsted should:
— ensure inspection judgements on behaviour and safety assess how well schools are tackling VAWG including sexual harassment and bullying, looking for evidence of all forms of violence against girls in schools; and
— carry out a thematic review/survey into how well primary and secondary schools are tackling VAWG.

The Education Select Committee should:
— conduct an inquiry into how schools are responding to VAWG.

The Equality and Human Rights Commission should:
— support schools, academies and colleges to meet their obligations to prevent violence against young women and girls under the Public Sector Equality Duty by producing specific guidance; and
— regularly monitor schools, academies and colleges to ensure compliance with the Public Sector Equality Duty and take action where necessary.

October 2011

Written evidence submitted by The Princess Royal Trust for Carers

1. Background

The Princess Royal Trust for Carers is pleased to provide evidence relating to the range of child protection issues affecting young carers.

The Princess Royal Trust for Carers currently helps approximately 31,000 young carers, between the age of five and 18, to cope with their caring role through its 83 specialised young carers’ services across the UK, from Orkney to Devon.

These services are part of The Princess Royal Trust Carers’ Centres, who are independently managed charities, offering young carers a chance to be young people free from their caring responsibilities through activities, clubs, outings, holidays and one-to-one support.
Young carers can also turn to The Princess Royal Trust for Carers’ interactive website, www.youngcarers.net which provides information, advice, email support and supervised message boards and chat sessions for young carers wherever they are across the UK.

2. The current situation

The 2001 census identified 175,000 young carers in the UK, with 13,000 caring for 50 plus hours per week. The Trust believes that these figures are a vast underestimation of the scale of the problem, and agree that more recent research provides us with a more realistic number: 700,000 young carers in the UK, approximately 8% of secondary school pupils.

Most young carers (81%) care for a parent, often a single parent. 58% of care recipients are mothers because single parents are more likely to be mothers than fathers. A quarter look after a disabled sibling, often when parents reach breaking point.

The range and scale of caring varies greatly. It can involve lots of physical care including: personal care; giving medication; helping someone to get up, get dressed or get around; looking after siblings; paying bills, cooking, cleaning and shopping. Some young carers give no physical care but provide emotional support, particularly for someone who has a mental health problem or substance addiction. This can have just as much impact on their lives as it can mean staying in to be there for someone when others are going out and socialising, reminding someone to take medication or dealing with the aftermath of an overdose attempt or drinking binge.

3. The impacts of caring

The impacts of being a young carer are great and often affect a young person well into adulthood.

A young carer’s physical health can be severely affected by caring through the night, repeatedly lifting a heavy adult, poor diet, lack of sleep or missing health appointments themselves. Stress, tiredness and mental ill-health are common for young carers who often report that they are anxious or depressed where caring roles and family situations have been particularly challenging. In addition, many young carers experience traumatic life changes such as bullying, bereavement, family break-up, losing income and housing, or seeing the effects of an illness or addiction on their loved one.

Furthermore, young carers personal and social development are often affected, as are their future career and educational opportunities and personal aspirations. 27% of young carers aged 11–16 experience educational difficulties or miss school because of their caring responsibilities, this rises to 40% where there is parental mental ill health/substance misuse. Young adult carers aged between 16 and 18 years are twice as likely as their peers to not be in education, employment or training (NEET). 186

It’s important to remember that the majority of young carers want to care and that few young carers ask to stop caring altogether. But caring roles become inappropriate when a young carer cannot choose the level of caring they provide and when it is having a detrimental effect on their health, wellbeing, educational and social opportunities. Without robust safeguards in place by all services, the impacts on a young carer are not only wide ranging, but can be both severe and enduring.

4. Why are the needs of young carers not effectively safeguarded by services?

It is true to say that many young carers still remain unidentified and consequently unsupported by services. This is especially true for those young carers with some of the most significant caring roles (particularly those caring for parental mental ill health and substance misuse). Parents remain wary of services and of the intervention that may ensue if they are to disclose the fact that their child cares for them. Young carers, too, are fearful of disclosing the fact that they are carers. Not only do they have concern about what services will do when they intervene, they also don’t feel confident that their situation will actually improve. In a survey for The Princess Royal Trust for Carers, 68% of young carers said that they experienced bullying at school which is often another reason why young carers will actively conceal their family situation.

Services remain fragmented. Services are still struggling to work together at both strategic level and practitioners lack the skills and knowledge to work with young carers and their families effectively. They are still failing to address the needs of the whole family. Adults’ services still do not recognise the impact of parental illness and/or disability on children. Some adults’ services still do not ask basic questions during assessments: Do you have children? How does your illness/condition affect you as a parent? How can we support you in your parenting role?

Children’s services are still failing to identify young carers before their caring role causes damage to their well-being. Schools have a vital role to play in the early identification of young carers and prevention of inappropriate caring roles, yet many schools still claim that they do not have young carers in their school and 39% of young carers reported that there was not a single member of staff in their school who knew that they were a young carer.

In addition, the focus on early intervention and prevention by central government is welcomed but with recent significant funding cuts, practitioners are increasingly less able to act preventatively and are forced instead to support those young carers (and their families) already in crisis and who are deeply entrenched in inappropriate caring roles. Thresholds for those needing care will be put under immense pressure with only those with the most complex care needs being provided with services. This means that many families are increasingly have to rely on the care of their child (or children) to do the things that social care had previously done or should have been doing.

5. What needs to happen?

It’s imperative that the commitments from the National Carers’ Strategy 2010 are implemented for young carers and carers alike. The strategy highlighted that more should be done to identify and support young carers and that services should be more “carer aware”. It set out the following commitments:

— Supporting those with caring responsibilities to identify themselves as carers at an early stage.
— Enabling those with caring responsibilities to fulfil their educational and employment potential.
— Providing personalised support both for carers and those they support.
— Supporting carers to remain mentally and physically well.

5.1 Whole family approach

We support the important, and much needed, work that is taking place at regional and local level around supporting the whole family. The “Families with Multiple Problems” agenda advocates and promotes a “whole family approach” which encourages services to work together to prevent individuals from being viewed in isolation, thereby helping to reduce inappropriate caring roles in the long term, empowering families and providing parents with the support they need to parent.

The Carers Strategy highlighted that: “A joint strategic approach by health, local government and voluntary organisations is needed for a local population to develop and commission a range of local services suited to the local needs of carers and people using services.” Services work best for young carers where local authorities retain a strategic role, where they have an overview of all services, including education, and where services—and professionals—join together around the needs of young carers and their families.

5.2 Education

Pupils who are young carers should be safeguarded in order to prevent them from undertaking inappropriate caring and from becoming a child in need. Schools are uniquely placed to support the early identification of young carers and to prevent situations from spiralling out of control.

Some schools now have a young carers’ policy that clearly sets out how they intend to identify and support young carers. Some schools are introducing a lead teacher with responsibility for young carers. In other areas, schools are working well with social services, through educational welfare officers, to support young carers who are, or who are at risk of becoming, NEET. We are also aware of some local authorities who are beginning to monitor young carers’ educational attainment and school attendance across a whole area.

Where caring roles are low, low-level support can be put in place and care plans can be drawn up to mitigate any future events. Simple things like access to a phone in break time, support groups where young carers can meet other young carers in their school and someone to talk to can often make all the difference.

Where caring roles are high, it’s imperative that schools must work closely together with agencies from assess.

We are aware of several areas that are displaying good practice in their support for young carers: Surrey, for example, has recently undertaken an area audit of how all schools are supporting young carers; Swindon has implemented a schools award that assesses schools against set criteria for how they support pupils who are young carers—schools can achieve the bronze, silver or gold award depending on the level of support they provide.

The Princess Royal Trust for Carers also recommends the use of the Pupil Premium in supporting young carers in school.187

Finally, support for young carers should not only be seamless across both health and social care, but also within the education system and in particular across all the transition periods from primary school to university. Achieving this may require joint commissioning of services across these boundaries and transitions.

5.3 Social care and health

In Supporting young carers: Identifying, assessing and meeting the needs of young carers and their families (2009), Ofsted reported that councils should “consider ways to ensure that adults’ and children’s services work

187 Pupil Premium: Support for Young Carers The Princess Royal Trust for Carers (2011)
together to deliver holistic assessments and services that meet the needs of the whole family.” An assessment of family circumstances is essential. The Trust advocates use of the Common Assessment Framework is used to understand what is happening in families and how illness and disability is affecting the family unit, the young carer(s) and the disabled person. Signposting or referring families to other services and working with other agencies, including health and adult’s services, can prevent a young carer’s caring role from impacting upon their own well-being and leading to crisis intervention.

The Trust also believes that services such as the Team around the Family (TAF)/Family Group Conferencing (FGC) should be used as much as possible to support whole families’ needs and that disabled parents—and families—should be supported to use individual budgets to prevent/reduce inappropriate caring roles.

5.4 Workforce development

Ofsted also reported that councils and partners should: “Ensure that professionals within universal services are aware of the needs of young carers so they can be identified and supported.”

We advocate that training and work shadowing across services takes place; all practitioners need to understand the needs of young carers and what statutory, universal and targeted services can do to support young carers and their families. As a result of this training, we believe that staff in schools will spot signs early, services working with disabled adults will check from the outset whether adults are parents, children’s services working with families with disabled children will consider the needs of siblings and services working with children understand the adverse impacts living with a disabled parent can bring. Finally hospital discharge teams, GPs and other staff will consider the likely impact of long term illness on a patient’s children.

October 2011

Written evidence from Shaun O’Connell BSc PGCE

INTRODUCTION

1. I have had extensive experience of the Family Courts in rather an unusual manner. I first met the Family Courts myself through divorce proceedings and was incredulous at the experience being a teacher with training in science, special needs and anger management. I submitted a paper to the Justice Select Committee which was published as additional evidence, and the panel needs to read that submission located at: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmjust/518/518vw02.htm

2. I have experience and knowledge which would assist the Committee in its deliberations. I am currently self-employed assisting family members with public and private law cases as Southern Family Aid, website www.southernfamilyaid.com. Lord Justice Thorpe on 20.10.11 in judgement described me as a respected and experienced McKenzie friend.

3. I missed the filing date for the prior deadline for submissions and so have covered some areas which related to the original enquiry which do not appear to have been covered at the end.

EXECUTIVE SUMMARY

4. The Education Committee most certainly does not have the expertise to consider these issues. In 2003 responsibility for child welfare was transferred from the Department of Health to the Department of children, schools and families. This was an illogical move. The responsibility should be lying with paediatricians and the Department for Health not within the remit of the Education Department.

5. Contrary to popular opinion Court time is not the problem (queuing for a 30 minute directions hearing) but Court time to deal with the case but time at hearing with the Judge having read the papers and prepared to raise the issues which are needed to be dealt with when the system is currently underfunded in terms of time available.

6. This would allow the system to operate as a forum for justice rather than a conveyor belt for lawyers and a local shop where the LA solicitors/social workers/CAFCASS officers are all well-known to each other. The system has become too cosy in local areas and poor practice and underhand acts routinely accepted as the norm.

7. Public law cases must be determined based on facts and with properly trained professionals providing independent reliable knowledge and research on physical or sexual abuse, emotional abuse issues must be reviewed by Parliament and pediatricians. The definition of abuse/neglect needs to be more closely defined. A holistic approach is badly needed to eliminate organic disorders and other factors such as diet affecting children’s behaviour.

8. Dept of Health to resume role of providing evidence based signs and symptoms on abuse/neglect issues and review emotional harm disorders and symptomology.

9. Use of experts to be restricted to issues requiring expertise and from someone practicing within the NHS not whose career is based on or forms the principal income from providing expert Court reports.
10. Role of CAMHS to be placed with the medical profession psychiatrists outside of the Family Court arena under normal NHS referrals and not social workers or psychobabble therapists.

11. Review of disorders and methodology of assessments based on the knowledge of the medical profession not therapists, social workers, CAMHS, hired guns or psychotherapy.

12. No fault complaint procedures to enable the truth to come out and wrongs redressed without fear of litigation as most parents simply want; the truth, an explanation and rights wronged or matters put into proper context.

13. Speeding up a failing system will result in an industry incapable of being held accountable, held in secret and with total disregard for families as the Empire building of vested interest bodies reigns supreme.

SUBSTANCE OF THE SUBMISSION

The impact of neglect and the long term consequences of a delay in intervention where there is evidence of neglect

14. First. What is neglect? Is it an untidy house, non-ironed clothes, failure to spoil the child, both or sole parent working and having less time, child not spending much time with parents (MPs children for example) or the child not gaining weight or losing weight due to malnourishment, overweight etc. Without a defined definition of neglect anything can be called neglect, a fact finding hearing held and as a result the child placed into long-term foster care for minor reasons or forcibly adopted.

15. The definition of significant harm in law is as follows:

Section 31 CA 1989 reads “A court may only make a Care Order or Supervision Order in respect of a child if it is satisfied that: The child is suffering, or is likely to suffer significant harm; and that the harm or likelihood of harm is attributable to a lack of adequate parental care or control”.

Under Section 31(9) of the Children Act 1989, as amended by the Adoption and Children Act 2002: “Harm” means ill-treatment or the impairment of health or development, including for example impairment suffered from seeing or hearing the ill-treatment of another; “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 that are not physical.

Section 31 (10) states “the question of whether harm suffered by a child is significant turns on the child’s health or development, his health or development shall be compared with that which could reasonably be expected of a similar child.”

16. In my experience and in common with others; few Judges, social workers, lawyers or CAFCASS consider the allegations in terms of the legal definition, instead once findings have been made, on what maybe minor issues or with evidence collated after the children have been taken into care and may bear no resemblance to the original reasons for the State involving itself, the findings are always sufficient to cross the threshold.

17. The Local Authority paints a blacker picture than is the reality which not only inflames parents but does not serve the best interests of the children. The pressures on local Authorities is such from their insurer Zurich, and to protect themselves from negative publicity that they will either take short cuts, over-exaggerate their case or even use underhand tactics to win their case. Examples include; with-holding material evidence from fact finding hearing thereby denying the parent material which can exonerate them from the allegations, mis-instructing their chosen expert, breaching procedure for questioning children on allegations, switching allegations at last minute, applying to stop contact just prior to finding of fact hearing to unsettle the parents and omitting relevant material from the Court bundle.

18. The Family Court has its own system of the child’s timetable which over-rides any prospect of a parent with problems from resolving the issues found. One year is outside the child’s timetable and a virtual rubber stamp to adoption.

Older young people (especially those aged 15 to 19) and child protection

19. Once children are of this age, they are highly unlikely to be adopted, often will not want to leave the family home and either the system has failed in addressing abuse prior if it has been ongoing for years (and costly in terms of the amount of work needed to overcome long-term abuse), or it is a one off incident and work with the family (as should happen no matter what the age of the child) will be the best way forward.

20. Sadly, many children are sexually active by the age of 13 never mind 15, and this has been encouraged by Government policies on provision of contraceptives, denying parents the right to know or see medical files if any child over 12 refuses to allow the parents to see them and the sexualisation of children in society. One could consider this Government induced sexual abuse.

21. Teenagers will test the parents patience as they go through adolescence. A parent may over-react. However, as long as the Government insists on child’s rights which demean parents rights and the rights of the
family as a unit, the conduct of teenagers will be worse than would otherwise be expected. It should be noted that many third world countries have better behaved children then in western democracies. We coped as a society better in the 1970s than now. Demolition of the nuclear family has been state induced in the so-called “best interests of the child” mantra.

Thresholds for intervention, for taking children into care and for adoption

22. As made clear above the Court can only make a care or supervision order if the conditions are met in law, but to take a child into care only requires suspicion of abuse or neglect. The Threshold is already too low. Ironically Baby P was a case of failure by the professionals but the gut reaction has been to remove many more children into care, just in case. This attitude needs to end.

23. I have been involved in few cases where there is evidence of what the public would call child abuse. Most problems could be resolved without needing to take Court proceedings. It only requires some time and energy.

24. Part of the problem is the way our society is currently malfunctioning and caused in part by the State demeaning rights of the family for individual rights for children. It is absurd that a 12 year old can refuse parental access to medical information or that children are encouraged to have under age sex.

25. Often family members are not considered prior to taking into care and should be the first route where care proceedings are considered necessary.

26. Mere suspicion at the outset often becomes inflated with the behaviour of the children ripped from their parents (the State bodies ignore the fact that the removal of children into care is a traumatic experience for children), with psychobabble reporting from contact centres with workers who are employees of the Local Authority and often their notes are inaccurate, only over-reporting negatives and again lack of understanding of the families trauma. Poor care by foster carers including physical injuries are routinely ignored.

27. Further, research in the USA shows that parents personalities change during the process and when tested six months after proceedings have ended their personality changes back. The very system causes this to happen and personality testing is often used by psychologists/psychiatrists against the parents.

28. There is no professional body or State organisation which considers if theories used in child protection are valid. Social workers and even experts routinely ignore best practice and ICD 10 criteria/NICE guidance. Judges are usually unaware.

29. In one case a child was removed from a parent on the basis that one of her children did not have Asperger’s syndrome (which is subtle in girls) when the expert under oath could not remember the criteria for diagnosis, and the District Judge did not care. On appeal the Circuit Judge hearing the full argument then omitted these and other issues from her judgement.

30. In another case the father was effectively framed by the Local Authority Solicitor and two social workers whereby relevant material facts and documents were omitted from every single chronology, case document and witness statements which were highly relevant to the defence to allegations of sexual abuse. The father was found guilty of sexual abuse on the balance of probability but two months later at Crown Court trial the Judge overseeing the disclosure process went through the social workers files and provided documents which revealed the facts which had not been disclosed. It is now also known that the mother in that case suffers from an ABI which the social workers and experts had not picked up on. One child to be adopted and three in long-term care. The Local Authority paid private barristers and in three years must have spent over £300,000 when had the professionals been professional a fraction of that money could have been used to help the mother with her ABI with adult social care and the father would have been found innocent. I have many more examples.

31. The panel refers like many MPs to attachment. Most stop thinking at this point. It is important for Committee to know that attachment theory is exactly that a theory. Not one single social worker, Guardian or expert has been able to inform how attachment is measured or assessed. Attachment disorders have very clear criteria in ICD 10.

32. All cases I have been involved in do not assess attachment according to the criteria. Further, the children’s behaviour when placed into foster care is used to justify the diagnosis and the trauma of having been taken from their parents/home is ignored. Attachment is purely a subjective view and should not be part of Court proceedings.

33. Ofsted have admitted that the Local Authority and other state bodies can use any theory they choose. This is absurd. CAMHS are making diagnoses of attachment disorders by social workers or therapists on flimsy procedure such as asking a child 23 short questions about fantasy scenarios with animals and then relating what they say in reply to their relationship with their parents.

34. Correct procedure is well-examined in the case of allegations of sexual abuse by virtue of the Cleveland enquiry and associated memoranda and culminating in the ABE procedure. The procedure whereby social workers, foster carers, parents etc must not question children about allegations of abuse are routinely breached. In one case which is very recent, the social worker’s statement was written up the day before she wrote her case notes, the case notes do not match her own statement. Further, the foster carer, social worker and foster
carer twice and the social worker and Police officer all rehearsed the child’s allegations with drawings and asked direct questions prior to an ABE interview. It appears that abuse of the process is deliberately done for advantage.

35. Any attempt to speed up the Court process is dangerous when already it is common practice for the LA employees to either make their case sound worse than reality or to get their findings upheld by underhand unlawful tactics with experts whom may rely heavily on further instructions from the LA. One expert has privately admitted that he makes £80 000 per year and it is more than his job is worth to provide a fair report.

36. There are no tools in law to remedy a miscarriage of Justice. Order 37 rule 1 no longer exists by virtue of the Family Proceedings Rules 2010. There is no legal route other than an appeal which leaves any analysis of the witnesses to the Lower Court Judge, and you have to show that either the judge was wrong in law (little in family law is mandatory, it is almost entirely discretionary), or the Judge was so plainly wrong no other person on seeing the evidence could make the ruling that he/she did, (whether that evidence is true or not). If new evidence comes to light it is devilish to get a re-hearing due to the cost as the appeal Court have made clear.

37. Once a placement order is made there can be no challenge to the order except by showing that the parent has overcome the difficulties the Court has found (whether true or not), and the High Court and Court of Appeal have ruled that sections 6, 7 and 8 Human Rights Act 1998 (an effective remedy as ruled by the House of Lords) was tantamount to an abuse of due process. So any consideration of changes must take into account the lack of due process afforded to parents.

38. Under current procedure any child can be taken into care. With the might of the vested interests of Local Authorities, Coram, BAAF, Tavistock, Barnardos (who as an example were given the contract for DV training by CAFCASS), private foster care companies, so-called experts and the protection of non-means tested legal aid, the side of parents and families is not being heard.

Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

39. The child protection system is in theory joined up and able to share information between agencies where child protection arises. However, there are fundamental problems with damage being done at an early stage with either knowingly false or hyped up information being fed into the process.

40. Parents are routinely denied access to the LA files. Guardians rarely check the LA files on behalf of the children. The LA has almost total control over the Court process, and often the LA leaps into care proceedings rather than assisting the parents where there are concerns.

41. Social work training is a void. Few social workers follow the LSCB procedures or good practice. Social workers are not trained in forensic process of investigation. As one social worker said “I am the law”. Judges rarely hold social workers to account using excuses such as “stressful job”, “overworked”, “high case load”, or “I am just grateful to have someone from the LA in Court”. It used to be commonplace for Judges to call the Director of social services to court to explain the misconduct of the social worker, but that was 15–20 years ago. Social workers know the legal game with repeated “I can’t answer that without seeing the file”, any lie is paid lip service to when caught out and some very poor practice is accepted due to the lack of social workers. I am surprised that Court protection social workers can sleep at night as I know many who do not have a clean conscience.

42. Social workers are not forensic, in my experience frontline social workers are accustomed to providing sexed up and even knowingly false dossiers. Social workers (and I have worked with them in my professional roles) seem to be affected by outside interests when the case is being prepared for Court and honesty and integrity are completely lacking.

43. Social workers are not medically trained, they are not child or adult psychologists/psychiatrists and neither are they competent in their own procedures. They often act outside their remit.

44. Social work is a woolly area of study. Rights for homosexuals and transsexuals and equality agendas permeate their thinking rather than assisting families which should be their concern. My best advice to everyone is never ask a social worker for help. In my own case the social worker under oath said “I can tell if a mother is emotionally unstable from over a mile away, I do not need to see them I can just sense it”. Sadly the judge believed every word.

45. It is quite clear that the agenda on adoption is a false one designed to save money from long-term foster care and being abused by those with a vested interest in profiting from it. We live in a democracy not a dictatorship.

April 2012
Written evidence submitted by the Association for Improvements in the Maternity Services (AIMS)

SUBMISSION TO HOUSE OF COMMONS EDUCATION COMMITTEE

1. WHAT WE DO

AIMS is an experienced pressure and support group, run entirely by volunteers, which has existed for 50 years. We give evidence to Select Committees and government, are stakeholders in many NICE consultations on medical care, work with the Confidential Enquiries into Maternal and Infant Deaths, and so on. We have links with a number of similar organizations in other countries, and also are active members of ENCA (European Network of Childbirth Associations).

2. HOW WE BECAME INVOLVED

We run a national help line for the UK, offering support and information to callers and those who contact us by email and post. The changing pattern in these calls often alerts us to new problems before they appear in the medical press or elsewhere. It was in this way that we became aware of an increasing number of calls from parents asking for help when threatened with removal of babies or young children by social services after the previous government set a crude target to “increase adoption numbers”. (The original brief at the Cabinet Office committee had been to look at “adoptions and permanence” for children in care) This target was reinforced by annual local authority inspections from OFSTED, and there were potentially large rewards attached. For example, Doncaster received over half a million pounds and Essex a million and a quarter for doing so well on their target. We dealt with distressed parents in both areas. Both local authorities were later downgraded to the lowest possible OFSTED rating for quality of children’s services: possibly the concentration on the high-reward adoption target had distorted their pattern of essential care for children.

We believe that the emphasis on adoption has distorted the pattern of care, and has increased parents’ fears and distrust of social services and healthcare professionals and has actually prevented the development of help and support for families in need. Because babies and young children became prime targets, this has had adverse effects on maternity and infant care.

It is not that we are opposed to adoption, when appropriate, (indeed, one of my own children is adopted and we are now besotted grandparents) and is an essential part of the pattern of care for children who genuinely can no longer remain with their birth parents. Adoption targeting is, however, only one of many problems within the system.

3. PUBLIC IMAGE OF SOCIAL WORK

The Munro Review of Child Protection (April 2011) refers to the “considerable evidence that the child protection system and social workers are portrayed very negatively in the media” and that there is a need to “help the public get a better understanding”. We can only say that this public image has been repeatedly borne out by our own observations and the hundreds of accounts we have received from families, as well as those from newer organizations which have been formed by parents in response to their experiences. Newspaper accounts of families’ bad experiences are invariably confirmed by extensive email correspondence from those with similar stories. Having worked in a local authority child care department in the days when there were properly trained child care officers, I find our case files deeply shocking. It is often even worse than media stories portray. And it is not just a few hard cases; it is widespread. The House of Commons Select Committee on Children, Schools and Families, in its report on Training of Social Workers found social work training not fit for purpose, and agreed with the points we had made in our evidence to them. However, the problem is not quality and training of social workers alone. Even when we observed families’ interactions with social workers who behaved pleasantly and professionally, they too were trapped in the same rigid computerised process, which actually prevented wider understanding and constructive solutions for real problems which some families had. In this we agree with Munro’s recommendations for change. But her recommendations do not go far enough.

4. CONFIDENTIALITY

Because we offer confidentiality to parents (a service no longer available in the NHS, charities in receipt of official grants, and many other support groups like Women’s Aid), we are trusted by those who contact us, and receive a great deal of information which, sadly, is often no longer shared with professional health carers by parents who fear referral to social services. We often have long-term contact with the families who come to us; we have met some of them and visited their homes and met their children, we have been present during social workers’ visits, have attended case conferences and review meetings, and (since we are accepted as advocates) have seen much official paper work, so we do not know only the parents’ side of the story.

5. MISLEADING REPORTS ON FAMILIES

We have observed contacts, and have seen how different descriptions in official reports may be from what actually occurs. These were not just errors or perceptions by individual social workers (of which we saw many examples) Minutes of meetings we attended at social service offices attended by many people in every case misrepresented what had happened. When we asked clients about this, they replied that it was “normal”, and
We were so concerned at the picture which was emerging, that in 2007, after analysing our first 50 cases, we wrote to Chief Medical Officer in England on the Adverse Effects on Public Health of Child Protection.

10. EARLY EVIDENCE OF HARM

We were so concerned at the picture which was emerging, that in 2007, after analysing our first 50 cases, we wrote to Chief Medical Officer in England on the Adverse Effects on Public Health of Child Protection. (attached) We were seeing long term trauma to families who had been investigated even briefly, babies taken into care being denied breast milk despite its many proven benefits, women now afraid to report domestic
violence or pregnancies resulting from rape for fear of being reported to social services and losing their children, concealment of postnatal mental illness for the same reason despite the fact that postnatal suicide was the largest single cause of deaths associated with childbirth, increased marital breakdowns after such intervention, and so on.

11. STRESS DAMAGES THE UNBORN CHILD

All these problems continue and even more worrying data has emerged. Severe stress in pregnancy which causes anxiety has been shown to have independent long term adverse effects on the health and behaviour of the child after birth, and these effects continue into adulthood. (V Glover, T O’Connor Effects of antenatal stress and anxiety: implications for development and psychiatry Br Journ Psychiatry 2002 180: 389–391) We are, of course, used to working with mothers whose pregnancy is stressful for many reasons, but the stress for both parents in cases where social service referral is threatened or actual during pregnancy is as bad as, and often worse than, anything we have worked with before, and is, of course, prolonged into the postnatal period.

12. SCREENING FOR POTENTIALLY HARMFUL PARENTS

All pregnant women are now routinely screened for supposed “risk factors” to their unborn child, and positive identification is likely to result in referral to social services, or the threat thereof, despite the fact that there are no studies as to whether this improves outcomes for the pregnancy, the birth process, or long or short term on the child and it is known such screening will create many false-positive cases. Yet research now shows that the anxiety created in the mother is almost certainly doing more harm to the unborn child than that which the mother may be at risk of causing later. An alternative approach would be to provide supportive and caring services for all pregnant women suffering any outside cause of stress, and not to add any further cause for anxiety. This is one of many examples where child “protection” aimed at identifying parents as potential abusers (the “witch-hunting approach”, as our clients call it) rather than offering truly supportive services, is doing more harm than good, and is damaging children even before birth permanently and seriously to a greater degree than the mother might do.

13. LACK OF KNOWLEDGE OF MATERNITY CARE

Even experienced social workers know little about pregnancy, childbirth, breastfeeding and the sensitive time and needs of parents in the postnatal period. (AIMS written evidence to Select Committee on Children Schools and Families on Training of Social Workers) We have had many examples where their ignorance has been damaging (eg a nervous mother near term with her first child traumatised by the social worker who told her the pregnancy could be outside the uterus; if true, she would have made medical history). Yet they blithely intervene with prescriptions for what the mother must do to show she is compliant and satisfy their criteria if she is to keep her baby. They have even issued dangerous medical instructions and advice in several cases. The problem is compounded by the fact that while local authority Safeguarding Teams include a nurse, they do not include a midwife, and we have had cases where the nurse’s ignorance of maternity care, and assumption that she knew things which she did not, led the team seriously astray.

14. LACK OF TRUE SUPPORT FOR PARENTS AND FAMILIES

On many occasions we have seen cases where families in genuine need of help are longing for truly supportive services, but they do not exist. We have seen too many cases where a simple request for what we see as legitimate help has led to parents who had openly asked for constructive help had been tramlined into the only pattern of response which now seems to exist—the punitive and damaging labelling of parents as inadequate or dangerous, and threatened or actual removal of all or some children We have seen a number of similar cases highlighted in the press, and this risk is now well known in communities, and serves as a warning to others. Whilst the Munro Review recommends an increase in supportive work—increasing the size of the carrot—the stick is to be moved just a little further into the background. We believe this change does not go far enough.

15. HEALTH VISITORS

Because of their enhanced role in child protection, Health Visitors are now widely known as “the health police” and increasingly mistrusted. We know, from our many calls on the subject, how often they are actually deterring families from consulting them about real problems, and how they increasing distrust of official services. The Munro Review calls for expansion of the service. We believe that restoring trust and confidence in their work will be a long and difficult process. They too have unquestioningly accepted recruitment into a rigid, damaging system, which as professionals they should have looked at more critically. And midwives are, of course, used to working with mothers whose pregnancy is stressful for many reasons, but the stress for both parents in cases where social service referral is threatened or actual during pregnancy is as bad as, and often worse than, anything we have worked with before, and is, of course, prolonged into the postnatal period.

16. RISKS FOR FAMILIES WITH DISABILITIES

These unmet needs are particularly apparent in families who have a parent, or one or more children with chronic disabilities. Because they become unpopular with local authorities for demanding expensive services or educational facilities which are in short supply, and they also are in frequent contact with health services
where they also have often to act as patient or child advocates, they may be at particular risk of damaging and unwarranted social services intervention. In their cases, threat or use of child protection procedures is a means of exerting power, gaining control, and ensuring compliance.

17. SOCIAL SERVICES AS A MEANS OF CONTROL

We are seeing an increasing number of cases where referral to social services is seen as a means of controlling or silencing pregnant women or parents who are seen as asking for services an individual health worker or teacher does not want to provide, which may be legitimate but inconvenient (eg women who want home births, or to avoid repeat caesarean sections), or who refuse recommended treatment—inevitably for good reason. Social workers and some midwives and doctors seem to be unaware that coerced consent is not legally valid. Also we, and other consumer groups, have seen a number of cases where child protection referral has been used maliciously in an attempt to silence parents who have made a justified complaint about a midwife, doctor, health visitor or teacher. The adverse effects of this have been so severe in a number of families, that we, one of the most experienced organizations in the country in dealing with health care complaints at every level, are very wary indeed of advising clients to complain once any social services intervention is remotely possible, or to complain on their behalf ourselves, despite the fact that some involve serious issues of public safety.

18. A DIFFERENT WAY

Fortunately, on the other side of the Atlantic, effective and impressive research has taken place. At last someone was using the gold standard to study outcomes: a large scale randomised trial. In Minnesota, after exclusion of cases where children appeared to be at immediate and serious risk, over 5,000 families referred for social work investigation were randomly allocated to either the standard process—like ours—of seeking out damaging and dangerous parenting, or to an Alternative Approach, which was supporting the families and trying to obtain help they needed. The families were followed up for an average of three and a half years. An Executive Summary of the Minnesota Alternative Response Evaluation by L Anthony Loman and Gary L Siegel and is available at http://www.iarstl.org/papers/FinalFRAReportExecSum.pdf and the full report is available at http://www.iarstl.org/papers/ARFinalEvaluationReport.pdf. (There are a number of publications on this work) The study was repeated in Missouri, with similar positive results, and this Alternative Approach has now been adopted in a number of other states in the USA. The most important finding was that the Alternative Approach did not damage child safety; there was evidence that it actually improved. There were less likely to be new maltreatment reports, though children were less likely to be removed. Both families and social workers liked this approach, and social workers were more popular. Moreover although initial outlay may be greater, it did not prove more expensive.

19. REDUCTION IN HARM, INCREASE IN BENEFITS

Harms and benefits to children and families are outlined on pp 66–68 of the full report, which is published by the Institute of Applied Research in St Louis Missouri. What struck us immediately was the similarity of adverse effects from the current approach to those we had seen in our own cases, which now amounted to hundreds. Anecdotal evidence however, does not impress policy makers, but well-designed, large scale, trials with long-term follow up, cannot be ignored.

(a) The percentage of families who felt more able to care for their children had declined with the standard approach, but increased in the supportive Alternative social work. This exactly fitted the picture of the many parents who told us that they were less confident in coping with their children than they had been before they had had even short-lived contacts with child protection processes.

(b) Economic stress had also increased in families subject to standard social work—again confirming parents’ accounts to us.

(c) Children in families who had traditional social work had had more serious illness than before social workers intervened, now had increased days off school from illness, complained more often of being unwell, had more trouble than before in learning at school, were more likely to refuse to go to school, were more likely to seem depressed, were slightly more likely to be difficult to control and more likely to engage in delinquent behaviour.

(d) Children in families who had Alternative social work had less serious illness than before, fewer had trouble learning at school and they got on better with other students, and were less likely to engage in delinquent behaviour and were slightly less likely to be difficult to control. Rates of missing school through sickness, school refusal, and acting depressed were unchanged, and complaints about being unwell had increased. As the authors point out in their summary table on p 68, “the direction of the change was persistent across items, always a little worse for the children in the control group and a little better among children in the pilot”.

Ev w188   Education Committee: Evidence
20. CONCLUSION: DOING HARM TRYING TO DO GOOD

This confirms the picture we have seen over and over again in our families, and from accounts reported by other consumer support groups. The official approach has been to identify bad and dangerous parents (though some will always be missed under any system) and to remove their children at the earliest possible age, when adoption has the greatest chance of success, or to “re-educate” parents. The standards as to what is acceptable parenting—which in our experience vary from social worker to social worker, area to area, and of course over time—are not publicly discussed, and the public for the most part have no idea what is being done in their name. Those who make the observations and judgements are woefully undertrained and under-equipped for this task. We know that many previously normal, affectionate parents and their children have been deeply damaged by the current investigative process, and far more seriously than the Loman and Siegel studies show. As for families who already had problems and needed constructive help, they did not receive it, and all emerged worse than before. Children removed as babies and adopted will, we hope, be flourishing, but there are likely to be future problems for them and their adoptive parents when they seek out their origins.

Jean Robinson
President
Association for Improvements in the Maternity Services

Prof Sir Liam Donaldson
Chief Medical Officer
Department of Health

ADVERSE EFFECTS OF CHILD PROTECTION ON PUBLIC HEALTH

You may recall that we sent you our analysis of our first 50 or so child protection cases when you first started looking at problems with medical expert witnesses. We read your most helpful document on supply and training of expert witnesses with interest, and responded to the questionnaire, and have seen your brief summary of responses. We are now preparing our second round of comments as NICE stakeholders on diagnosis of child abuse (greatly concerned, incidentally, at the truncated definition of the amended scope).

Medical opinions, however, are but a part of the system which impacts on children and parents. We are now so concerned at the adverse effects of child protection procedures in the UK that we felt we had to write to you. As a group which runs a national help line, we are seeing how serious, long-lasting and widespread the adverse effects of these expensive interventions are. Since, as advocates, and occasional Family Court witnesses, we see many case and court files, we know how questionable and inaccurate are the allegations, interpretation and documentation from which many investigations spring. Sometimes it is unclear where the trail began, and a surprising number seem to start after justified consumer complaints have been made about health care or other staff.

When instructions went out to all staff in contact with children to report concerns about risk, this seems to have been done with little prior thought, without consultation, and without provision for training. The result was the post-Climbie cover-your-back syndrome: “when in the slightest doubt, report to social services.” We see a huge variety of standards, misunderstandings, prejudices, ill-informed interpretation of risk factors, cultural incompetence and even racism, in the initiation of cases from health visitors, teachers, midwives, nurses, doctors and others. Quite apart from the damage to families, each one of these reports pre-empts resources and often leads to substantial, and unnecessary, cost. Ironically, the basic, simple help or real support families would like, is unavailable because resources are lacking, that is not the focus of social work activity, and anyway nowadays many parents are afraid to ask because any contact with social services is too risky.

Community information grapevines work, and effectively circulate information about what people see as the growing risk of being investigated or labelled as a dangerous parent after contact with medical care. The risk is not merely perceived: it is real, and the consequences are devastating. Damage to the whole family structure (sometimes the extended family network and its support structure), to parental confidence and self-esteem, to children’s sense of security and safety, and their sense of security that their parents can and will protect them—these are very serious adverse effects. Often we find it is the most sensitive parents, to whom family life means everything, who are most damaged. We also have many concerns about damage we have seen to authority of black parents vis-a-vis their children, many of whom are already coping with multiple racial prejudice problems. As we have pointed out to NICE as stakeholders in their consultation of diagnosis of child abuse, such potential for harm must now be considered, and it is long overdue. The sheer cultural incompetence of many social workers has to be seen to be believed.

The following list is not exhaustive, but gives examples of typical problems. We make no claim for their being representative of the whole picture of child protection activities, of course, since we deal only with those who come to us for help. However, the problems we are finding seem to be echoed by other groups.

1. FEAR OF ACCESSING MEDICAL CARE

Nowadays parents call us and ask for advice when their children have accidents, because they are afraid to go to A & E, and they know we run a totally confidential service. We cannot give such advice as we are not qualified to do so. We have been in existence for well over 40 years and can recall no such requests until about
four years ago. There is now no health professional, or official help line, parents feel they can safely ask for help. All agencies, including NHS direct, will report anything they regard as suspicious. Innocent parents who have had one brush with the system, or social services investigation, or whose friends, relatives or neighbours have, now find the risk of avoiding treatment preferable to the risk of damage to the whole family of going for help.

2. Distrust of Health Visitors

Mothers are opting out of seeing health visitors, and are advising friends not to see them, after they, or someone they know, has had a similar encounter. Those who feel obliged to do so, tell them as little as possible. One incident and they tell us “I’ve made sure everyone in the village knows not to trust her”. In some areas, however, merely opting out of seeing a health visitor (maybe because they don’t like her, or find her advice or manner unhelpful) is cause for referral to social services in itself—thereby confirming the increasingly common perception of them as the “health police”. Those who do see the health visitor are highly circumspect about the information they give.

3. Adverse Effects of Medical Investigations

Small babies with a tiny bruise are automatically given whole-body X-rays at an early stage. (“Those who don’t cruise, rarely bruise,”—“rarely” being interpreted as “never”). The likely cause has sometimes proved to be equipment such as a baby-carrier or push-chair. Sometimes a boisterous older sibling—a toddler—is suspected but this cannot be proved. The parents, not unreasonably, are now continually worried about the future possibility of leukaemia. As these whole-body X-rays are now so common, (there should be a database of such exposures) the likelihood of this in some children must be increasing.

4. Concealment of Postnatal Mental Illness

As at least two studies have shown, mothers are lying in response to the questions on the Edinburgh Postnatal Depression Scale and they are concealing post natal mental illness, for fear of social service intervention. We knew this from our help line, long before the research appeared. A formerly useful, validated, screening tool no longer works. This is alarming since suicide is the largest cause of deaths associated with childbirth. We are dealing with seriously ill women, and we know that contact with child protection services only worsens their state but it is as if no-one cares. One immediately suicidal mother was told by her GP “We don’t have to worry now: the baby is safely in care.” Everyone concentrates on safety of the baby, though statistically the chances of the mother killing herself are very much greater.

The known serious long-term adverse effects for a child of losing a parent through suicide are not even considered. We seem to be the only remaining group who see mother and baby as a dyad, and think they need to be treated as such. The Confidential Enquiries into Maternal Deaths report cases of suicide which are directly related to women’s fear of social services taking their children—real or imagined, and points out what a large number of children have been orphaned by post-natal suicide. These suicides are, of course, only measured for the first year post-natally, but we have clients at risk, and know of cases, long after that. We have many cases where social services intervention is intensifying and prolonging the very postnatal depression which they are seeing as the reason to take their babies. We have never yet seen a case where the mother found social worker intervention helpful or supportive. In the last fortnight I have worked with two women who I feel are suicide risks (one acute) solely as a result of social service management. As their babies are now over a year old, their deaths would not be included in the statistics, but we are prepared to give evidence to coroners if the worst happens.

There are no Paternal Death statistics. Naturally postnatal mental illness in mothers is our major concern, but we are hearing of more and more cases of fathers tipped into depression by child protection investigations. The intervention itself is frequently toxic to mental health, and greatly damaging to self-esteem, which is particularly important where it is fragile to begin with, or families are already dealing with racism.

5. Loss of Breastfeeding

Many mothers whose babies were precipitately removed, (they, and we, suspect as potential adoption material to meet targets) but had to be returned when a case could not be made, grieve for the loss of breastfeeding, with its long term benefits for mother and child, and for the damage to bonding. If and when children are returned, they are unable to re-establish it. One woman recently told us of the profound difference in feelings towards her two children, the first of which was affected by child protection actions and threat of removal, and the second, which had a happy normal birth. It is a story we have heard from a number of others. Even the threat of intervention or suspicion can cause serious damage in the sensitive postnatal period, and we have vivid descriptions from parents.

In a number of cases mothers have expressed breast milk and begged social workers to give it to the baby, and they have refused. Others have not openly refused but mothers later discovered it was thrown away. One baby (an adoption target) was recorded by a paediatrician as “bottle fed from birth” though all the notes clearly indicated otherwise. More recently some breast feeding mothers have been asked to express milk by social workers (we suspect as a result of European Court human rights decision on one of our UK cases P, C and S
v. UK 16 07 02). They dared not refuse since it might lessen the chance of the baby’s return, but firstly this is often very difficult for the inexperienced primigravida, and the continued lactation (and oxytocin levels) added to their distress at the baby’s absence (a price all lactating mothers pay). It was not a choice those particular mothers would have made. In some cases the stress has caused lactation to fail totally, and the mother is further devasted. This is NOT a case that social workers are “damned if they do and damned if they don’t”, but that their ignorance and the way they use (and mis-use) information to strengthen their case often works adversely for both mother and child.

6. INCREASED USE OF ALTERNATIVE PRACTITIONERS

After a brush with the system, more families in our files are avoiding orthodox medical care and increasingly turning to alternative practitioners for their own, and their children’s care. Whilst many parents are full of praise for the alternative practitioners they use, we have concerns about lack of paediatric and medical knowledge. I have never forgotten interviewing the mother of a young child who died from diabetes when parents followed such advice. Parents with ongoing medical problems are also foregoing care for themselves because they no longer trust the system.

7. MORE CHOOSE HOME SCHOOLING

An increasing number of children in our files are being removed from school and are home educated, sometimes after a fairly minor brush with “protection” services, because the educational system (including nursery education) is now seen as part of the surveillance process, which can be influenced by the whims, prejudices and occasionally hostility of individual teachers. Another child was removed by nursery school because the teacher there was questioned by social workers about the parents and is no longer trusted, so it is at home.

8. MORE SEPARATIONS AND MARITAL BREAKDOWN

We have lost count of the number of marriages and partnerships which have broken down as a result of the intense stress caused by child protection investigations of what turned out to be innocent parents. The children now have an absent father and are largely cared for by the traumatised mother. This loss alone is far more damaging to the child than the potential harm of which parents were initially accused.

9. REDUCED PROSPERITY AND WELL BEING

We have been surprised to see how often families suffer considerable financial loss and are in reduced circumstances because of intervention. This includes both the poor and the middle class. The stress, and time-consuming nature of trying to fight their corner, takes all their time, and often erodes their health. There is no longer time, or money, to take the children on outings they would once have had, for example. Making photocopies, postage of documents, paying for copies of their records and faxes, and so on, eats into the limited resources of those who have little to spare. Some are prevented from pursuing former careers where local well-circulated, and unproven, suspicions have made them unemployable, yet there is not a shred of evidence that they are unfit.

When social services depart and have closed the files, the family may well have turned in on itself. Sometimes they have felt they could not talk about what is happening to neighbours, friends, or even relatives. Sometimes they fear stigmatisation. Sometimes they are stigmatised. Garbled, distorted stories may have been circulated in schools, clinics, churches, etc. Contact with friends, neighbours, clubs, even relatives, may be reduced sometimes drastically. Their social capital—known to be an important factor in mortality and mortality—has been reduced.

10. LACK OF HELP FOR THOSE IN NEED

Parents whose children have behavioural or educational difficulties now feel there is no confidential, trustworthy source of help they can go to. It was sometimes those very difficulties (then undiagnosed) which led to the interventions, but when everyone else goes home, the parents are left to cope with them, often now worse than they were before, but with nowhere they can, or dare, turn to.

Parents who cannot avoid the system, because they have disabled children, find themselves in a continual weary battle to preserve their sanity, their integrity and their self-esteem. There is a lot of black humour in our phone calls: we agree they are “the lucky ones” in that their children are so seriously disabled, social services and doctors don’t want to take them (they would be too expensive and risky to keep in care, and are not seen as adoption material) but the perception is that professionals just want to exert power and control everything they do, rather than listening to parents who have found out what works and helping them with basic, simple needs.

Because we run a totally confidential service, and never report anyone to anywhere, we are told a great deal which would be helpful to professionals involved with family care, but which they will never know because now all are required to report suspicions, so none of them is trusted.
11. Concealment of Rape Conceptions

Women whose pregnancies are the result of rape are not mentioning this to anyone, though they are desperately in need of support and sensitive care, for fear of social service interference. We are supporting them as best we can, especially since we saw the disastrous effects after a woman confided in her midwife, who reported to social services in another case.

12. Concealment of Sexual Risk

Parents who have had a brush with the system withdraw from being part of the watchful community group which helps to protect all children. For example, a number of them have told us about sexual activities of quite young fellow pupils at their children’s school (which now seem surprisingly common) or grooming attempts by local paedophiles. Whereas at one time they would have acted, now they keep quiet in case any activity re-awakens interest in them or their children. They are no longer willing to try to protect other people’s children: they have pulled up the drawbridge. In view of the number of cases we have seen where women who reported paedophiles and ended up being disbelieved or vilified themselves (the assumption that these genuinely concerned mothers were making it up for their own ends, in custody battles etc) we do not blame them.

13. Concealment of Domestic Violence

Women who are suffering domestic violence are continuing to conceal it for the same reason. Since we have seen cases of babies removed from such women, even after they have left their violent partners and are coping well, we are not surprised.

14. Child Protection as Social Control

Use of child “protection” or threats thereof, are increasingly being used to control parents who are seen as unorthodox, or not completely compliant. (The social worker’s ideal “compliant” mother does not seem to be one who would have the personality to insist that other people don’t smoke near her baby. Yet “stroppy” mothers can be advantageous to children, protecting them when they live in difficult social circumstances. Heaven help the disabled child or one with special needs who does not have at least one stroppy parent to fight for him). The message is getting round quickly, and parents are opting out of official sources care even more, or being even more selective on what information they give, and what they conceal.

15. Toxic Psychiatric Labels

Your recent report confirmed the picture we have from our cases, that psychiatrists greatly outnumber paediatricians as court experts in Family Court cases. Selected experts are invited by social workers to confirm that the parent who complained about the health visitor, or who has criticised or challenged them must have a “personality disorder”(not uncommon); this has now replaced the rather discredited Factitious and Induced Illness (frustratingly rare) as the method of choice. Judges do not ask the simple question: what is the baseline of this in the community, and are we to remove the children of all such parents? Where is the evidence that this child is, or has been, at risk from this parent?

The result is that many parents and children, even if not separated and found guilty of no harm, have now acquired permanent damaging labels—widely circulated among shared records—which they, and we, suspect are likely to be a permanent source of prejudice, which do not contribute in any constructive way to their care, support, treatment or interaction with services. Since the condition is widely regarded as untreatable, there is no responsibility on the psychiatrist or the NHS to treat, but there is total freedom by lay and medical personal to disregard what the parents say.

There is a substantial literature on the effect on professional attitudes of any label such as “personality disorder”, for example, and how it affects attitudes to the patient and hinders diagnosis and prevents treatment. Yet many families are acquiring these labels as a result of totally unjustified intervention in the first place. In many of our cases specific psychiatrists and psychologists seem to have been called in when social workers were unable to find evidence to prove the case they wanted. Despite our strong suggestions to clients that they should obtain copies of the psychological tests carried out on them, so that conclusions may be challenged, and their validity for different cultures assessed, so far no-one has managed to do so. (Incidentally, we are also concerned at the number of cases where these same professionals then go on to recommend to the court that the family needs exclusive private treatment by themselves at a cost of many thousands of pounds.)

As with paediatricians and Munchausen Syndrome by Proxy, experts who are knowledgeable, are seen as unbiased, and will give evidence for the parent are as scarce as hen’s teeth. When a child has some physical problems, there is hope that the truth that the mother was not wrong in believing her child to be ill, will emerge eventually, through advances in medical knowledge, or even at post mortem. With psychiatric opinion of a parent’s state at the time, what hope is there of rebuttal? The MSBP label carries its own unique trail of damage: anything the mother reports to any authority is not believed—or rather is automatically DISbelieved, by doctors, teachers, the police etc, and we have seen cases of actual endangerment because of this.

Medical opinions can be wrong. Has everyone forgotten that once all the paediatricians and health visitors were ordering mothers to place their babies face down to sleep? We know a number of older mothers who did
not “comply” with that—they just liked to watch their babies’ sleeping faces. And maybe some of their children were saved from cot death as a result.

I could go on. But you can see why we are so concerned. Unless both professionals and the courts understand how common, and how serious, the adverse effects of child protection intervention and investigation can be, how can they balance the risks of action versus leaving well alone?

April 2012

Written evidence submitted by Nisai Virtual Academy

THE IMPACT OF NEGLECT AND HOW STABILITY IN EDUCATION CAN HELP NEGATE IMPACT OF NEGLECT

What is Neglect?

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs. Some statistics on neglect in the UK include:

- Approximately 46,700 children are known to be at risk of abuse;
- 25.3% of young adults were severely maltreated during childhood;
- 14.3% of young adults were severely maltreated by a parent or guardian during childhood;
- 11.5% of young adults experienced severe physical violence during childhood at the hands of an adult;
- 9% had been severely neglected by parents or guardians during childhood;¹⁸⁸
- There were 375,900 children in need at 31 March 2010 (341.3 per 10,000 children);¹⁸⁹ and
- 58% of looked after children in England and Wales on 31 March 2010 became looked after because of abuse or neglect.¹⁹⁰

How can neglect impact on children?

The consequences of the abuse vary according to differences in the duration and frequency of maltreatment. However, it has been established that:

- Abuse can be especially damaging during the critical period of infancy, and affect children especially during their school years.
- Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress including low self-esteem, severe anxiety,¹⁹¹ post-traumatic stress disorder, self-harming and means a young person is at double the risk of attempted suicide by the time they reach their late twenties.¹⁹²
- Abuse increases the risk of a child being bullied.¹⁹³
- For children with disabilities, the usual risk factors for child abuse (ie dependence and vulnerability) are intensified. When a child or young person is disabled, injuries or behavioural symptoms can mistakenly be attributed to the disability rather than the abuse or neglect.
- The MRI and PET show that there are chemical and structural differences between the central nervous systems of abused and non-abused young people.¹⁹⁴ There is also an association between childhood abuse and hormonal disruption, manifesting in a dysregulation of the HPA (hypothalamic pituitary adrenal) axis.¹⁹⁵
- Abuse can inhibit the appropriate development of certain regions of the brain¹⁹⁶ because a neglected infant or young child may not be exposed to stimuli that normally activate important regions of the brain, hampering the child’s functioning later in life. As a result, the brain may become “wired” to experience the world as hostile and uncaring, prompting the child to become anxious, overly aggressive, emotionally withdrawn and increase their likelihood of suffering from dissociative disorders, attention deficit/hyperactivity disorder or reactive attachment disorder.¹⁹⁷
- Maltreatment may affect a child’s health indirectly. Physical and sexual abuse is a major factor in the homelessness of young people.

¹⁹¹ Kendler et al, 1998
¹⁹² Gilbert et al, 2008
¹⁹³ Duncan, 1997
— In one long-term study by Silverman et al (1996), as many as 80% of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder by the time they reached age 21. Indeed, evidence shows that around 50% of people receiving mental health services report abuse as children, with one review finding that “on careful questioning, 50%–60% of psychiatric inpatients and 40%–60% of outpatients report childhood histories of abuse.”

**Barriers to children seeking help**

Whilst it may seem obvious that young people caught within the trap of neglect need help, many children and young people feel that they do not have anyone that they can turn to for support. They may have sought help in the past and had a negative experience, feel they will not be believed, or worry about the lack of trust they have in the services that have been provided to help them. Indeed, a report by the Mental Health Foundation into self-harm showed that many young people suffered ridicule or hostility from the professionals they had turned to for help.

In addition, there are particular issues for vulnerable groups of children. Any child may have difficulty finding the right words to explain a problem or concern but a child who has communication difficulties will find the problem strongly compounded by the lack of communication systems available to them. They will also be less likely to have the social networks in place to enable them to talk to a friend ie: children in residential care are much more likely to keep things to themselves than children living at home.

**Early intervention to help prevention**

A recent report by Graham Allen MP outlines the case for early intervention. However, even though children’s rights are laid out in the UN convention on the rights of the child, which provides a framework for understanding child maltreatment, there are still many young people who fall through the gaps and do not have the support they need. These are usually children who may have been excluded from mainstream education due to illness, disability, behavioural/mental health problems or child poverty, as they are at the most risk of being isolated.

Plus, it is of equal importance that services are run by staff with whom young people have trusting relationships. It is therefore vital that attention is paid to enhancing opportunities for positive, non-violent family and peer interactions through educational provision.

**How can the NVA help?**

The Nisai Virtual Academy (NVA)—created by the Nisai Group—is an award winning online learning community and real-time teaching environment that is internationally recognised as a world leader in personalised learning. It enables those who are excluded from traditional education due to illness, disability, behavioural/mental health problems or child poverty, to access full and proper education online.

The NVA is completely interactive, allowing students to move around the online campus, whilst using the same frameworks, as a student would receive in a traditional school. For example:

<table>
<thead>
<tr>
<th>Frameworks offered by the NVA</th>
<th>Frameworks offered by a traditional educational environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The user logs on</td>
<td>Registration at the start of the school day</td>
</tr>
<tr>
<td>A highly personalised timetable</td>
<td>Some degree of personalised timetabling</td>
</tr>
<tr>
<td>Students’ learning is extended and consolidated through tasks set by teachers that students complete outside lessons, supported through NVA online community and technology</td>
<td>Homework and independent study sessions</td>
</tr>
<tr>
<td>Extra curricular activities ie: music and book After school clubs clubs</td>
<td></td>
</tr>
</tbody>
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It also offers students access to behavioural management specialists in order to reduce learning barriers, ensure students are able to engage and participate in learning and that the students are given the tools they need to work through the issues that may have brought them to the position they are now in.

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199 http://www.nspcc.org.uk/inform/research/questions/barriers_to_seeking_help_wda70246.html
203 UN General Assembly, 1989.
Advantages of using the NVA to help children who have been neglected

— The NVA is successfully providing young people disenfranchised from mainstream education with a framework for educational success, creating a much greater likelihood that these young people will become economically independent individuals that can establish their own values, allow them to look positively to the future and give young people the ability to feel positive about themselves so they can escape the past and break the cycle of abuse.

— In line with the Government’s wish to “bring in new ways of teaching and learning to make every child’s education the best it can be,” the NVA promotes best practice. If one Local Education Authority has considerable experience in assisting vulnerable students, they can act as a conduit to share this best practice with other authorities, increasing understanding and standards overall.

— Ofsted has found that Councils often don’t make use of the national IT system that identifies children missing from school. By enrolling children into the NVA, students will not only be educated, but procedures in the NVA system will ensure the students won’t slip under the radar again.

— The NVA works closely with Staffordshire University’s Education department to create a Masters’ level CPD module which teaches teachers to effectively teach the “hard to reach” online, ensuring that a completely new, interactive and effective teaching methodology is used to engage students and help them develop and move forward. This helps to cement the impression that the NVA is a “sensitive” organisation that is not seen as part of the system, but as a positive guiding force for each student.

— In line with the Government’s intentions to deal with bullying, the NVA organises classes by ability meaning that every student can maximise their own potential and that they can work within their own comfort zone, without risk of bullying from others. The NVA promotes a caring environment and so instances of bullying are rare, however the recording of all live lessons ensures that any incidents of bullying can be investigated and dealt with quickly. This supportive environment allows young people to break free from the cycle of generational neglect, as the NVA fosters a caring approach to all its learners and teaches them not to judge and to treat others with respect.

— The NVA helps young people to support each other through the forums. This helps equip young people with the skills and tools they need to support their friends/peers and family members and bring back positive feelings and actions into the home. The forums also help to tackle the myths about those who seek help and show that seeking help is not a sign of weakness but can build solutions.

CONCLUSION

Intervening at an early stage can reduce a child’s likelihood of developing long-term health problems, and also reduce the public burden, as the young person is likely to grow up happier and more independent. The importance of preventing child neglect cannot therefore be underestimated. With this in mind, promoting online learning communities like the NVA allows children and young people who may be estranged from mainstream education to be included and provides opportunities for them to be successful.

April 2012

Written evidence submitted by the Advice on Individual Rights in Europe (AIRE)

INTRODUCTION

1. These submissions by the AIRE Centre to the Education Committee follow the latter’s request for additional evidence following its revised terms of reference in its inquiry into the Child Protection System in England. These submissions deal with two of the interlinked re-focused topics posed by the inquiry, namely:

   (i) The impact of neglect and the long term consequences of a delay in intervention where there is evidence of neglect.

   (ii) Thresholds for intervention for taking children into care (considered in the context of neglect).

2. The AIRE (Advice on Individual Rights in Europe) Centre is a London based charity providing free legal advice on European Convention on Human Rights (ECHR) and European Union Law. The AIRE Centre provides advice to legal representatives on these issues, conducts training for judges, lawyers and state official on individual rights under European Law and represents individuals (or assists their representatives) before the European Court of Human Rights (ECHR) and other international bodies. It has also intervened as a third party in cases before the Court of Appeal and the Supreme Court.

3. Over the past 15 years, the AIRE Centre has been involved before the European Court of Human Rights in many cases involving the child protection system in England. This includes cases where the local authority has wrongly identified children for being at risk of significant harm from their parents and so did not identify...
the serious medical condition from which the children were suffering (AD and OD v The United Kingdom [2010] ECHR 340, RK and MAK v The United Kingdom [2010] ECHR 363). The AIRE Centre has also been involved in cases where procedural safeguards during the child protection process were not followed (TP and KM v The United Kingdom [2001] 34 EHRR 42, P, C and S v The United Kingdom [2002] 35 EHRR 1075), or where the responsible local authority has failed to implement the care plan submitted to the court making the care order.

IDENTIFYING NEGLECT

4. The AIRE Centre was part of the legal team representing the applicants (instructed by the Official Solicitor) in the landmark case of Z and others v The United Kingdom [2001] 34 EHRR 97. Here, the applicants were five children who had suffered serious physical and mental ill-treatment as a result of chronic neglect and emotional abuse by their mother and her partner. This amounted in the view of the ECHR to a violation of the prohibition on torture and inhuman and degrading treatment enshrined in Article 3 of the Convention. It found that the local authority were aware of the serious ill-treatment and neglect suffered by the children and yet failed—for five years—to take any effective steps to bring it to an end. The local authority social workers were extremely reluctant to act because they had not identified any physical abuse resulting from non accidental injury, only what they termed “neglectful parenting”. The case was one of the first to highlight the devastating effects caused not only by neglect but also delays in intervention by the local authorities. The children were all noted as suffering severe psychological trauma as a result of their ordeal and significant damages were awarded since it was clear that the children would require therapy for a prolonged period—perhaps for the rest of their lives.

5. Although the incidents in the above case occurred some time ago, the case remains an illustrative example not only of the dangers of ignoring neglectful care and but also of the reluctance of local authorities to institute care proceedings under section 31 Children Act 1989 when neglect is in issue. Although the circumstances under which the court may make a care or supervision order are defined under section 31, there is limited statutory definition as to what constitutes ill-treatment for the purposes of the child suffering (or likely to suffer) significant harm—the non-exhaustive definition of “ill-treatment at section 31(9) Children Act 1989 does not mention neglect. It should be noted that the UN Convention on the Rights of the Child 1989 (hereafter referred to as the “CRC”) specifically states that separation of a child from his/her parents may “be necessary in a particular case such as one involving abuse or neglect of the child by the parents” (Article 9). (The CRC is a standard which is also applicable to compliance with the ECHR as a consequence of Article 53 of the ECHR, which requires the Convention to be implemented consistently with other international instruments to which the state is a party. The ECHR is a part of domestic English law following the Human Rights Act 1998).

6. In cases where there are no obvious signs of ill-treatment resulting from non-accidental injury, the question of whether the harm suffered by the child is grave enough to warrant triggering the local authority’s child protection mechanism may fall to varying interpretations. This can lead to situations where children are left to suffer prolonged and totally unacceptable neglect. Although the initial assessment of a child’s situation is often made by a sole professional whose determination of the situation may be subjective, it is important that there are basic common standards which can be used when considering the issue of neglect and when it is serious enough to require local authority intervention.

THE THRESHOLD OF INTERVENTION: IDENTIFYING CHILDREN AS RIGHT-HOLDERS

7. The AIRE Centre invites the Committee to recall that the ECHR and the CRC demand that the basic standards to be used in deciding when a situation warrants intervention should be rooted in the understanding that children are right-holders themselves. The comments which follow are confined to the issue of determining whether the threshold for intervention, compatible with the positive and negative obligations imposed by the ECHR, has been reached. The procedure following intervention by the local authority and the courts such as placement of the child, assessments following intervention and the parents’ rights within proceedings are separate matters not within the inquiry’s re-focused request for evidence and are therefore not addressed in these submissions.

8. The AIRE Centre has represented many children in cases before the European Court of Human Rights and in the course of that litigation has been surprised by the lack of awareness shown by local authorities that children have their own rights under the ECHR. Local authorities including “front-line” professionals are well aware that parents have the right to respect for their family life (under Article 8 ECHR, as incorporated into domestic law by the Human Rights Act 1998); they are also aware that the welfare of the child may necessitate a proportionate infringement of the parents’ rights. However they often fail to approach the situation from the perspective of the rights of the children themselves, rights which may necessitate an interference with the parent’s rights.

9. While children (and their parents) are of course entitled to respect for their family life (under Article 8), this must be balanced against the child’s right to respect not only for family life but as importantly for “moral and physical integrity, that is physical and psychological well—being, protected under the private life rubric of Article 8 (see X and Y v Netherlands [1985] 8 EHRR 235). Circumstances at home which result in the child not being washed, sleeping in soiled sheets, not being appropriately dressed, not receiving adequate or appropriate nourishment interfere with a child’s right to respect for his “moral and physical integrity”. The
local authority is under a positive obligation to ensure that this state of affairs is not prolonged by inaction. It is important to note that such neglect does not have to reach the “threshold of severity” to be characterised as inhuman or degrading treatment absolutely prohibited under Article 3 ECHR. A failure to give effect to the child’s right to “moral and physical integrity” will violate Article 8 of the ECHR unless it is clearly justified.

10. As the ECtHR has frequently stated, Article 8 not only protects substantive rights but has “inherent procedural safeguards”. These safeguards must be triggered automatically once evidence (such as the examples given in paragraph 12 below) indicates that proper compliance with a child’s rights may be lacking.

11. Yardsticks to be used in determining whether the threshold of intervention has been met—when neglect is suspected—can usefully be based on the CRC which has already prescribed minimum standards for States to respect and ensure in relation to children. Standards such as:
   — Article 24 (“the right of the child to the enjoyment of the highest attainable standard of health”).
   — Article 27 (“the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development”).
   — Article 28 (“the right of the child to education”).
   — Article 31 (“the right of the child to rest and leisure”).

Whilst all of these yardsticks taken together are important, it is perhaps Article 27 which most clearly sets out the standard to be met.

12. The AIRE centre does not suggest, for example, that a parent missing several of a child’s health visitor appointment and thus diminishing the child’s rights under Article 24 will eo ipso amount to neglect and would, without more, be serious enough to meet the threshold for intervention. However, such omissions may need to trigger an investigation in the round into the child’s home situation in accordance with the rights they enjoy under the CRC.

13. It follows that, if a child is:
   — not taken to health care appointments as required by the health visitor and vaccination programme;
   — not attending school regularly;
   — clearly hungry and/or malnourished;
   — frequently seen with dirty clothes; and
   — suffering from poor personal hygiene.

Then the local authority cannot ignore the situation. When alerted to the matter by schoolteachers, neighbours or other family members, the local authority must be aware of the rights guaranteed to all children and not delay a prompt investigation which is capable of leading to a prompt intervention. Initial steps may include convening a child-protection conference, allocating a social worker to the family so there is continuity of professional involvement or instigating an investigation and providing a report under section 47 Children Act 1989 before taking the next step and deciding whether the threshold for intervention for a care application has been reached.

14. The local authority must not ignore the situation on the basis that the child’s parenting is “good enough” given his/her circumstances in life. It is the recognition of and compliance with the child’s rights that must be “good enough” and if those yardsticks are not met, should compel action.

April 2012

Written evidence submitted by the National Association of Head Teachers (NAHT)

1. The National Association of Head Teachers (NAHT) welcomes the opportunity to submit evidence to the inquiry into The Child Protection System in England. Schools and colleges play a significant role in the identification and protection of children “at risk”; NAHT represents over 28,000 school leaders across the 0–19 age range and beyond and, as such, is well placed to comment on this issue.

The Impact of Neglect and Long-Term Consequences of a Delay in Intervention

2. Few would argue that the long term effects of neglect can be as catastrophic for children and young people as other forms of abuse. It causes school leaders considerable distress that schools are often powerless to do anything to alleviate the obvious suffering of the children they serve.

3. Schools and colleges witness many different forms of neglect and are aware that it arises from a range of parental circumstances including lack of interest and disregard, mental health problems, learning disabilities, work/financial pressures and chaotic drug and/or alcohol use. It is also important to stress that neglect is not the preserve of those from low socio-economic groups. Examples of neglect regularly observed by schools include:
   — Children arriving in schools in unwashed clothes or clothes that are inappropriate for the season;
   — Children arriving at school hungry, without food or any means of purchasing a school lunch;
Children displaying extreme fatigue suggesting that they are not getting sufficient sleep;
— Young people arriving to school either “hung-over” or under the influence of alcohol or drugs;
— Children rarely laughing, smiling or interacting with their peers;
— Disclosure of information about their lives outside of school that suggest that the child is receiving inadequate supervision and care and/or are exposed to unsuitable and potentially dangerous influences;
— Unexplained or contrived explanations for bruising, burns or other injuries; and
— Marked changes in behaviour from “the norm”.

4. Speech delay, continence issues, poor impulse control and a lack of dexterity can also be observed in children who have not received sufficient care and/or attention during their early years.

5. A particularly distressing effect of neglect that can be observed is the social isolation experienced by children who are neglected at home. A child who smells, is dirty or perhaps lacks the social graces of their peer group can quickly be singled out by other children for negative attention. Schools work hard to tackle this issue and promote inclusion, but cannot facilitate the party invitations, and other out-of-school social activities that many such children are excluded from.

6. The long term impact of parental neglect within an educational context includes poor attendance and punctuality, low levels of attainment and progress and disruptive and oppositional behaviour. Other associated behaviours that schools are aware of include chaotic drug and alcohol use, violence, criminal behaviours, early sexualisation and vulnerability to exploitation.

7. It is often difficult for schools to deal with the issue of poor attendance patterns in cases where there is suspected neglect, particularly with older children. Cases often “ping-pong” between education welfare and social services in terms of lead responsibility resulting in teenagers falling between services and not receiving the support they require.

8. Schools try to compensate where they can for the neglect experienced by the child or young person. Some schools keep a supply of spare clothes (including underwear) for use by children whose parents are unwilling or unable to dress them appropriately. They provide food during the school day, but cannot help but worry about whether that child will receive a hot meal during the weekend or holidays. They also frequently provide mentors and other support services. However, when a child is frequently moved from area to area and school to school it becomes increasingly difficult to sustain the same levels of support. Indeed many school leaders and teachers say goodbye to a vulnerable pupil not knowing whether that child will get to attend another school for quite some time.

9. For many children, school is the most secure and positive environment they experience. High levels of diplomacy are often required in keeping a child in school once problems of neglect have been identified as these parents are least likely to engage constructively with the education workforce.

10. However, children whose basic physical and emotional needs are not being met frequently (and perhaps unsurprisingly) struggle to access the mainstream school curriculum and schools continue to experience unacceptably long wait times for access to specialist help and support systems.

11. Sadly, the delay in providing assistance to pupils and families in need often creates the false impression that the school or college doesn’t care. This can damage trust and make providing future support more difficult.

12. NAHT members can relate numerous accounts of children whose lives were significantly improved thanks to the intervention of social services. We believe that current thresholds for intervention and removal need re-examining and would wholeheartedly support intervention at a much earlier stage.

Child Protection and Older Young People (15—19)

13. Whilst some features of child protection are common to all groups of young people, the 15–19 age group present particular challenges for schools and colleges.

14. This age group enjoy higher levels of independence and self determination than other pupils and this makes them more vulnerable to particular types of risk.

15. On-line safety continues to be major concern. Young people frequently share personal information online which leaves them vulnerable not only to physical and emotional exploitation and abuse, but also to crime such as fraud and identity theft.

16. People in this age group remain susceptible to grooming (which may have begun much earlier in their lives) but are more likely to perceive some types of sexual exploitation/abuse as a choice. In these instances the young person is less likely to disclose what is happening and indeed may deny and/or actively attempt to conceal abuse/exploitation that is occurring and/or protect the identity of their abuser.

17. Many young people are placed at risk due to unstable domestic arrangements including frequent changes to the adults living within the household.
18. Forced marriage remains a concern within some communities and school leaders have welcomed recent attempts to support them in detecting and preventing this from occurring.

19. Particularly challenging for schools and colleges is managing the risks presented by members of the student body. Many schools and colleges have pupils who are on the sex offenders register, have been convicted of serious violent crimes or have a history of deeply problematic behaviour, yet their peers and members of the education workforce are unaware of this fact. More work is needed on how to manage peer-to-peer safeguarding within this context.

20. Similarly, gang-membership and recruitment activities continue to pose a serious risk to many young people, yet many schools and colleges are not fully confident in the identification and support of those young people potentially vulnerable to this type of activity.

21. Schools and colleges still find assessing competence levels a challenge when working with this age group. “Age—appropriate” behaviour is much harder to assess at this age than in pre-puberty and schools and colleges would welcome further guidance in these areas.

CONCLUSION

22. It is understandable that, when faced with limited resources and a need to prioritise, Social Services will often focus on the youngest children as they are least able to support themselves. However, too often the opportunity to transform the future of a young person aged 15–19 is lost due to the inability of the existing system to provide equivalent levels support to this age group.

23. Identifying (and tackling) neglect and/or other child protection issues require high levels of vigilance and confidence from education professionals. In recent years a significant amount of attention has been given to ensuring that schools and colleges have appropriate systems in place for reporting safeguarding concerns. It is now time to place a greater emphasis on identifying and supporting those at risk, providing teachers and school leaders with more opportunities to share their low-level concerns with other practitioners and act more efficiently to prevent possible future abuse.

24. NAHT would welcome the opportunity to provide further oral evidence to the Committee if required.

April 2012

Written evidence submitted by ADCS

1. INTRODUCTION

1.1 ADCS is the national leadership organisation in England for directors of children’s services appointed under the provisions of the Children Act 2004 and for other children’s services professionals in leadership roles. The statutory role of director of children’s services (DCS) was created by the Children Act 2004 to establish a single point of leadership and accountability for services for children and young people.

2. THRESHOLDS FOR INTERVENTION

For taking children in to care and for adoption

2.1 We welcome the Committee’s further consideration of thresholds for taking children in to care and for permanently separating them from their parent(s).

2.2 Recent representations by the Government’s adoption adviser Martin Narey calling for more children to be taken in to care more quickly and for more and speedier adoptions have raised fundamental questions about the purpose of “public care”—When and how should the state intervene in families’ lives? When is it right to permanently remove children from their parents’ care and place children for adoption with the severance of the legal ties between birth parents and their children this entails? Who should make the decision to remove a child from their parents’ care? We would welcome a public debate on this to inform the development of future safeguarding and child protection policies and services.

2.3 We agree that for some children, being taken into care early can be the best way of improving their life chances and outcomes; for some children in some circumstances, care really does work. We unequivocally support adoption as one form of permanence for the placement of looked after children and young people. Adoption is an important facet in a successful care system but it is important to maintain a sophisticated understanding of the range of permanence options available and to remember that adoption is an unusual option by international standards. What research evidence seems to show is that stability is a more important factor in predicting emotional, behavioural and educational wellbeing than the type of placement. So the outcomes for children placed in long term stable foster care for example may be broadly equivalent to the outcomes of their peers who have been adopted. This is important as adoption is not appropriate for all children. Not all children wish to be adopted207 and we know that for many children adoption does not work. We firmly believe

it is local authorities working in partnership with statutory and voluntary agencies, children and families that are best placed to make these decisions.

2.4 We believe that the legal basis for intervention set out in the Children Act 1989 remains sound. The issue is how the interpretation of the thresholds set out in the Act have developed as government and local government policy has evolved and through practice in the courts in public law proceedings.

2.5 In line with the statutory framework, local authorities work with partners to agree thresholds that all partners understand. The effectiveness of this and the shared understanding local partners have of thresholds is evidenced by Ofsted inspections.

2.6 This shared understanding of thresholds for intervention and referral remains key to effective child protection regimes. We know that children who are neglected and their parents are unlikely to seek help directly from “child protection” or “safeguarding” services. 208 We also know that parental problems such as alcohol and drug abuse, mental health problems and domestic violence can increase the risk of a child suffering harm. It is often the services provided by police, probation and health agencies that work with adults to change their behaviour that will make the most difference to the risk of harm to children. Effective child protection regimes will include consideration of the thresholds for adults receiving support to prioritise those adults with children who may be at risk. We welcome the acknowledgement by Ofsted that some local authorities have reversed the upward trend in referrals and that “the effective commissioning of early intervention and preventive services and embedded partnership working at the front line have ensured that only those children who require targeted support or intervention from social care are referred to those services” 209.

2.7 The Association strongly believes that long term decisions regarding the care of vulnerable children must emerge over time and be flexible to changing circumstances. Rarely are child protections cases clear cut and predictable with absolute certainty. The current system is set up to deal with “known’s” but care proceedings must also be able to deal with “unknowns”, such as whether a parent will significantly improve their parenting after undertaking treatment for drug addiction for example.

2.8 We support the full implementation of recommendations in the Family Justice Review (FJR) 210 which we believe will help to deconstruct the adversarial nature of public law which is not well suited to cases before family courts, particularly as in the majority of cases there is no dispute on harm or cause of harm. It proposes a desperately needed rationalisation of current structures and processes alongside workforce reforms to achieve increased leadership capacity and clarity of roles and responsibilities of different organisations and individuals involved. We particularly welcome the proposal to refocus the work of the courts on the fundamental question of whether a care order is in the child’s best interest and less on the local authority care plan.

3. IMPACT OF NEGLECT AND THE LONG TERM CONSEQUENCES OF A DELAY IN INTERVENTION WHERE THERE IS EVIDENCE OF NEGLECT

3.1 There is a growing body of evidence about the lifetime impact of poor care in infancy and of the poor outcomes for children who have suffered serious harm and are returned to parents where there has not been transformational change in the quality of the parents’ care. We know that intensive, long-term provision of services is often needed to support children who return home and their families. 211

3.2 We welcome the contribution recently published research by Farmer, Kingsley, Barlow, Ward and others has made through the joint Department for Education/Department of Health Safeguarding Children Research Initiative to understanding of the impact of neglect.

4. OLDER YOUNG PEOPLE (15 TO 19) AND CHILD PROTECTION

4.1 We recognise that many young people may be at risk of abuse and neglect. Teenagers feature in a quarter of serious case reviews. 212 It is often difficult to detect abuse and neglect of older young people. Their neglect and abuse can be masked by their troubling and risky behaviour which becomes the focus for public intervention by local authorities and criminal justice agencies. As actors in their own stories, young people may face a wider range of risks than young children due to their increasing independence, including their lifestyles and social networks. Young people can often find it difficult to disclose their experiences of neglect, abuse or maltreatment because of their awareness of the potential impact of the disclosure on themselves and on their families. We know that building a trusting relationship with a professional is an important factor in whether or not a young person makes a disclosure. We are concerned that the reduction in youth services in response to considerable budget pressures reduces the contact professionals will have with young people and

208 Daniel, B. et al “Noticing and Helping the Neglected Child Literature Review” www.education.gov.uk/publications/eOrderingDownload/DCSF-RBX-09-03.pdf

209 Ofsted Annual Report 2010/11, p. 120.


212 Mike Stein “The Neglect of Adolescent Neglect” http://media.education.gov.uk/assets/files/ppt/adolescent%20neglect.ppt
therefore the opportunity to build the most effective relationships for identifying young people who are at risk of abuse or neglect and supporting them.

4.2 Some young people are drawn into the child protection system. However, child protection may not necessarily be the most effective mechanism to meet their needs. Local authorities can draw on Child In Need or Common Assessment Framework processes to respond to the needs of older young people. Both targeted and specialised services, such as those working to prevent sexual exploitation and those linked to the criminal justice system, and open access services, such as those promoting the wellbeing of families, are crucial to effectively identifying and supporting older young people who are suffering from abuse or neglect.

April 2012

Written evidence submitted by The Adolescent and Children’s Trust

INTRODUCTION

1. TACT (The Adolescent and Children’s Trust) is a national charity for children and young people involved in the care system. We are the UK’s largest charity provider of fostering and adoption services. We also campaign on behalf of children and young people in care and on the edge of care.

2. The focus of the inquiry is child protection. As a leading provider of care services, TACT has many years experience helping children in the care system achieve and lead successful lives following transition to independence. For example, our most recent assessment of outcomes for the young people in our care showed 90% leaving our care due to age went into further education or employment.213

3. We have also developed a research base of particular relevance to this inquiry. It demonstrates how the right interventions in the care system can transform a young person’s life, building resilience and protecting against risk. In this response we will refer extensively to the TACT reports, “Aspirations: Three Years on” (2011),214 a longitudinal study into the views and experiences of children in TACT care and their carers and the recent work, published jointly with the University of East Anglia (UEA), “Looked After Children and Offending: Reducing Risk and Promoting Resilience” (2012).215 It is worth noting that although the latter work focused on the criminal justice system, it involved interviews with many children in care who had never been in contact with the police. The findings are, therefore, relevant to all aspects of care.

4. Before considering the three inquiry questions one overarching point should be made. Frequent references are made in the media and via statistical data to poor outcomes for children and young people who have been in care. In comparison to their peers they under perform in education, criminal justice, employment and so on. This could imply that entry into care is responsible for failure. As a consequence, the care system itself can be seen as problematic. This simple interpretation is incorrect. The reason for these poor outcomes is not the care system but the abuse, neglect or chaos that almost certainly precedes entry into care. Unless mitigated, the damage caused can have a permanent and catastrophic impact upon life chances. When the care system works, it can build resilience and transform lives. When it does not, the damage already done can be compounded.

5. Protecting a child or young person from risk of immediate harm, abuse or neglect by placing them in care (or using other alternatives such as kinship care) is only one aspect of child protection. When the state acts as parent there is an ongoing obligation to child protection, not just to keep from harm, but to ensure the best chance of future success. That is the focus of this response.

THE IMPACT OF NEGLECT AND CONSEQUENCES OF DELAY IN INTERVENTION

6. It is an obvious yet necessary point to make that the longer the delay in intervention the greater the potential for damage to a child or young person. The concept of early intervention has, therefore, become central to policy drivers across the political spectrum and has been greatly assisted by the work of Graham Allen MP. There is, however, a danger of interpreting “early intervention” to mean “early years intervention” only. Of course, intervention in early years can be extremely effective. Indeed, the TACT/UEA Care and Offending research has established that children taken into care at a young age are at significantly lower risk of entry into the criminal justice system. This does not mean that intervention in adolescence is either too late or financially ineffective. Intervention can take place at any age. It is “early” when prompt action is taken to address the young person’s needs.

7. The TACT/UEA Care and Criminalisation work identified five main areas where neglect and entry into care can impact. These are: (1) trust in relationships; (2) mentalisation, affect regulation and moral reasoning; (3) self-esteem; (4) self-efficacy; and (5) belonging, identity and values.216 There is not the space in this response to go into these in detail. However, all these factors carry both the opportunity to develop resilience and the danger of increased risk. Key to the development of resilience is the capacity to reflect on and resolve feelings about the past, to move on and manage complex issues in the present and to be able to look forward.

214 http://bit.ly/zTPi26
216 Ibid 3 at page 124
with a degree of hope. Increased risk develops from the reinforcement of negative impressions of self and surroundings through poor care experiences.

8. Examples of how resilience and risk can be developed can be derived from anecdotal evidence gained from research. The contrast between these quotes from the 100 young people interviewed for the TACT/UEA Care and Crime research is striking:

“I wasn’t a good child at all because my birth family never showed me any love… I was always angry, all the time. And then my foster mother saw what was going on and she knew. So she gave me love and she gave me what every mother should give their daughter and I changed my ways and now I don’t do drugs or anything bad like that”.

“I never really cared about anyone apart from myself—that was me when I was little. I didn’t care about nobody… Because I didn’t think anyone cared about me. I had been moved about so many times, it doesn’t make you feel wanted does it, being moved around”.

9. Stability is at the heart of improved resilience. It is the platform for positive outcomes. All of the 56 young people involved in TACT’s Aspirations research had been in the same placement for at least three years. The impact of this stability upon their wellbeing was dramatic. For example, the young people were asked 14 questions concerning school with the opportunity to respond “Excellent”, “Good”, “Average”, “Below Average” and “Need more help” to each question. Overall, 81 percent responded with replies of either “Excellent” or “Good”. Similarly, they were asked about their involvement with a selection of 20 activities. The responses showed that nearly all the activities were carried out by at least some of the children. “Days out”, “computer games”, “swimming”, “hanging out with friends”, “cycling”, “play station”, “reading” and “football” were all enjoyed by at least 74% of the young people. 217

10. The converse is, of course, that if children in care do not have stable placements with sensitive caregivers and do not have the appropriate professional support, they will be at risk from a range of poor outcomes.

11. Ultimately, TACT believes that while the long term consequences of neglect can be lifelong and profound, entry into the care system gives a window of opportunity to mitigate the impact and allow the young person every opportunity to achieve their ambition.

OLDER CHILDREN AND CHILD PROTECTION

12. As mentioned above there is a danger that excessive focus on early years interventions means that interventions for adolescents, who may well have experienced years of neglect, are not considered economically viable. This is particularly the case in times of economic constraint, when all public expenditure is scrutinised for cost effectiveness.

13. While there is certainly evidence of the cost effectiveness of early years intervention, there are aspects of adolescence where the right action can have particular benefit. If interventions capitalise on the protective potential of relationships, involvement in constructive activity and involvement in decisions about their care and future the impact can be hugely beneficial. In the TACT/UEA Care and Offending work it was striking how positive adolescents who engaged with activities were. Comments such as “I like learning new stuff and everything”, “I looked it up on the internet, thought ‘I’m going to try it’ and fell in love with it [martial arts]” and “Hobbies—I would say technology—I love it, can’t get enough of it, anything new that comes out” are clear evidence of positive engaged mindsets. The Aspirations work, which showed how stability leads to positive engaged young people also emphasised the value of relationships. Ninety six percent of the young people involved described their relationship with their current foster carer as ‘very important’. Meanwhile the same study saw 84 percent of the young people having ‘a lot of say’ in talking about big life decisions affecting them with a further 12 percent saying they had some say”. 219

14. It is clear from these examples that engagement with older young people carries particular opportunities that, if taken, allow them to develop resilience and succeed. It is crucial that care policy recognises this so that adolescents have the same opportunities as those who enter the care system at a young age.

THRESHOLDS FOR INTERVENTION

15. There is an inherent danger to changing thresholds for intervention without very strong evidence that change is needed. The tragic case of Baby Peter, and the subsequent increase in children coming into care, is no more based in policy need than were reactions to allegations of overzealous care applications during the Cleveland child abuse scandal in the 1980s. TACT does not believe that there is a particular need to review the current basis for entry into care. As a UK wide organisation, we are however aware that different local authorities have differing applications of the care threshold. While statutory reform might not be necessary, greater consistency is.

16. TACT acknowledges that, as in all things, both care and adoption processes are capable of improvement. We hope that the review of adoption currently taking place will identify positive areas of change. In particular,
we believe that care and adoption planning should seek to introduce permanence (if appropriate) whenever possible. As stated earlier, TACT maintains that the most effective way of protecting children in care and developing resilience is by seeking permanence whenever possible. Adoption is not the best option for achieving this in all cases. In particular, while adoption might be a more suitable option for younger children it is less likely to be appropriate for those in middle or older childhood. Long term foster care is often the best option, particularly if the young people have siblings and other extended family. This will help them maintain their relationships and identity (see paragraph 7 above) which otherwise might be lost following adoption.

17. Processes which are child centred and aim to achieve permanence with the minimum of change or transition are ideal. The effectiveness of concurrent planning (which aims for foster carers to become adopters if reunification with the birth family is not possible) is well documented. We would also suggest that concurrent planning with family support services can help transitions into care when it does not prove possible for a child to remain with its family. For example, TACT is currently in discussion about a similar concurrent model. The potential partner offers intensive residential services aimed at supporting at risk families so that their children are supported and protected. If it does not prove possible for a family to stay together, TACT is seeking to work with the residential service provider and the relevant local authorities to provide as easy a transition as possible for the children into care.

18. We would urge the Education Committee to consider and make recommendations to protect children through permanence. For example, TACT believes that the recently introduced Scottish Permanence Order will prove extremely effective in proving stability for children who cannot live with their families but for whom adoption is not a suitable option. We would like to see the same introduced in England and Wales. For TACT, child protection is best achieved not by changing thresholds for entry into the care system, but by making the system provide stability and resilience for those who come into care.

19. We have placed all the emphasis in this submission on child protection through stability and permanence. This is because, as a service provider, TACT has seen myriad examples of how care can transform lives. The following is from a letter received in January 2012 from a 12 year old young person placed with TACT carers. It shows the difference care can make:

“I’m just writing to you to say thank you for a wonderful Christmas and for putting me in such a warm hearted family. They have given me the Christmas I’ve always dreamed of. They gave me presents I wouldn’t even dream of getting so again thank you for giving me a lovely family to keep me safe and look after me and help me when I need help and talk to me when I’m upset…This placement is the best one I’ve even been in”.

April 2012

Written Evidence submitted by the National Children’s Bureau (NCB)

Summary

This submission draws upon four key pieces of evidence: an audit of children’s needs in Pupil Referral Units (PRUs),220 a report on the attachment needs of older and socially excluded young people,221 a review of safeguarding within secure estate,222 and a report for NASWE on education welfare services.223

Key concerns identified in the research include:

- the lack of multi-agency planning;
- delays in tackling neglect and maltreatment for teenagers, which may result in educational exclusion or offending behaviour;
- health and social care services failing to take full account of the fact that young offenders are more likely to have a range of damaging experiences in childhood and may have insecure attachment as a result;
- tackling bullying or violence from peers in secure settings being the weakest area of practice, despite young people perceiving this as the biggest risk to their safety;
- the lack of a clear definition in secure settings about what constitutes a child protection concern; and
- overly high thresholds are an obstacle to Education Welfare Services being able to fully meet the needs of disadvantaged children.

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221 The attachment needs of older and socially excluded young people: report of an invited seminar held on 27 September 2010 (NCB 2010).
222 A Review of Safeguarding in the Secure Estate 2008 (YJB and NCB).
1. **OLDER YOUNG PEOPLE (ESPECIALLY THOSE AGED 15–19) AND CHILD PROTECTION**

**Child protection and Pupil Referral Units**

1.1 In 2009–10, NCB worked with staff from six Pupil Referral Units (PRUs) from across England to undertake an audit of the needs of 268 children attending those Units.\(^\text{224}\)

1.2 In this audit 41% of children’s needs were judged as not being met, and more than half (62%) of these unmet needs were judged to be affecting the children’s health and development in a significant way. The main areas of need identified were: adult/child relationships; the impact of loss and trauma; improved care at home; consistent boundaries at home; behaviour needing to be better understood and managed; and overcoming the impact of domestic violence.

1.3 Although the primary purpose of PRUs is to offer an educational intervention to young people, they are also places where a young person’s welfare needs can be identified and addressed. Staff said they were aware of the limitations of what they could achieve on this, and there was a lack of clear multi-agency planning.

1.4 Worry was also expressed by staff about their pupils’ future beyond PRUs. In the year 11 PRU, half the children (14 out of 26) did not have a clear post-16 destination and were therefore likely to become NEET as many were considered to be ill prepared academically and emotionally for this transition.

1.5 With their wider needs left un-addressed, and without the continuing benign influence of the PRU, pupils’ outcomes when they leave school are likely to be extremely poor. The PRU represents a last chance to engage with vulnerable young people before they reach adulthood and this opportunity should not be squandered.

1.6 Recommendations:

(a) PRUs must be equipped to offer/broker the different types of support children need.

(b) There is an opportunity with the implementation of the duty on young people to participate in education and training for PRUs to improve the necessary transition planning.

(c) There is a need for greater clarity about the purpose of PRU provision (and to commission and resource appropriately to support that purpose).

(d) There must be an improvement in multi-agency planning.

**Safeguarding and attachment**

1.7 The attachment needs of older and socially excluded young people were explored in a report by NCB in 2010.\(^\text{225}\) We know that young people who offend are more likely to have a range of damaging experiences in childhood and may have insecure attachment as a result. Health and social care systems sometimes fail to take account of this issue properly and services for this age group could be more effective if they understood attachment difficulties better.

1.8 There is a danger of “writing off” young people with attachment disorders because their challenges originate in early childhood, but there is growing evidence that therapeutic intervention continues to be possible. Interventions are likely to be ineffective if the young person lacks a secure base or if the intervention is badly timed.

1.9 Teachers, social workers, and even nursery nurses need training so that they can recognise attachment patterns and the impact on children’s behaviour of insecure/disorganised attachment. Training will not make a difference, however, unless the organisational context supports an attachment-based approach.

1.10 Recommendations:

(a) There must be greater recognition within the health, social care and youth justice systems of the attachment disorders and needs of vulnerable young people, under-pinning the development of an attachment-based approach in all settings.

(b) Practice with older young people could be improved through:
   — better tools for the assessment of attachment disorders;
   — ensuring relationships are at the heart of practice and continue when the child is “well”; and
   — stronger focus on the transitions that children have to make.

(c) In commissioning and practice, the importance of early intervention must not be lost, and this should be coupled with the idea of a “safety net” for those who have attachment disorders.

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\(^\text{224}\) Matching Needs and Services: An audit of the needs of 268 children attending Pupil Referral Units in 4 local authority areas (Liz Brown, NCB, May 2011).

\(^\text{225}\) The attachment needs of older and socially excluded young people: report of an invited seminar held on 27 September 2010 (NCB 2010).
Safeguarding in Young Offender Institutions, Secure Training Centres and Secure Children's Homes in England and Wales

1.11 A review of safeguarding was undertaken by NCB in partnership with the YJB in order to identify what more needs to be done to ensure the safety of children and young people under 18 within Young Officer Institutions (YOIs), Secure Training Centres (SCTs) and Secure Children’s Homes (SCHs) in England and Wales. In spite of the differences between the type of establishments, there were common themes across the settings where safeguarding could be improved. The review looked at how safe children were from harm from their peers, self or from adults.

Harm from peers

1.12 Bullying or violence from peers was the biggest fear for children within the secure estate. There was an express commitment to eradicating bullying, but many staff acknowledged it to be the weakest area of practice with a tendency to try to suppress it rather than tackle the root causes. Some children said that they were sometimes criticised for bullying for what they perceived to be normal adolescent behaviour. There must be clearer definitions and better training.

Harm from self

1.13 The possibility of self-harm was a major concern, sometimes leading to a risk-averse approach that could be detrimental to the young person. For example, children who were thought to pose a risk could have their rooms stripped of possessions in case they self-harmed. More focus was put on the surveillance needed to prevent opportunities for self-harm rather than providing support to tackle the underlying causes. There were distressing instances where young people were physically restrained for long periods in order to prevent self-harm.

1.14 Although secure estate staff were committed to improving practice, they did not always have access to the specialist or multi-agency support that they needed. They said they would welcome guidance on the proportionate responses to the different types of self-harm and more specialist services.

Harm from adults

1.15 Practice in all settings was hampered by the lack of a clear definition about what constituted a child protection concern, and therefore the threshold for referral to the local authority (LA). Establishments and Local Safeguarding Children Boards (LSCBs) had been left to make their own interpretations of the categories of abuse within Working Together to Safeguard Children in the context of a secure setting and had reached different conclusions. Associated with this confusion over thresholds, the meaningful involvement of the local authority was rare in YOIs. Finally, it was not always clear where decisions about the response to allegations would be taken with different staff being involved at different stages. Although instances of physical harm were likely to be investigated, there was poor recognition in YOIs of possible instances of neglect or emotional harm.

Overall sense of safety

1.16 The factors that contributed to a sense of safety were based primarily on the presence and attitudes of staff. Most young people said their establishment would be safer if there were more staff to young people. They felt the safest in SCHs and the least safe in YOIs, with STCs in between. The physical environment also contributed to a sense of safety with boys’ YOIs at a significant disadvantage, operating within inadequate and depressing buildings.

1.17 Recommendations:

(a) The message that young people feel safer in small units with adequate staffing levels needs to be used to inform the strategic development of the secure estate.

(b) The needs of young people in secure settings should be specifically addressed in national and local safeguarding policies.

(c) Establishments’ performance and inspection frameworks need to be rationalised to ensure consistent and child-centred standards.

(d) Engagement between LSCBs and secure establishments needs to be further developed.

(e) Staff should be better enabled to identify and support children at risk from self-harm and suicide, and to receive the multi-agency input they need.

(f) A working definition of child protection that is suitable for the setting needs to be developed, supported by explicit thresholds for referral to Las.

(g) Roles and responsibilities in relation to child protection decision making within the secure estate need to be reviewed to ensure that lines of accountability are clear and that suitable arrangements are in place.

A Review of Safeguarding in the Secure Estate 2008 (YJB and NCB).
(h) The culture within secure establishments is crucial, and trusting relationships between staff and children should be fostered so that children feel able to make their concerns known.

2. Thresholds for Intervention, for Taking Children into Care and for Adoption

Education Welfare Service in England

2.1 An NCB report for the National Association of Social Workers in Education (NASWE) describes the findings from an audit of 197 children in touch with education welfare services in four local authority areas. A major reason given by auditors for services only being partially met was that, while children’s social care services remain the gateway to children and their families being offered a wider range of support, high thresholds make these difficult to access.

2.2 High thresholds for children’s social care means that child protection concerns are not adequately addressed, multi-agency meetings are not called as often as they should be and/or intensive family support services are not provided. Considerable frustration at these high thresholds was expressed by staff.

2.3 It is also of note that the audit found little evidence of co-ordinated, needs-led, multi-agency planning in any of the areas. In the main, services operated on a single agency basis and did not routinely focus on children’s needs or develop plans which contain clear outcomes.

2.4 Recommendations:
   (a) Thresholds must be reviewed to ensure that child protection concerns are adequately addressed and families are offered a wide range of support and access to children’s social care services.
   (b) There is a need for co-ordinated, needs-led, outcome-focused, multi-agency planning.

3. The Impact of Neglect and the Long Term Consequences of a Delay in Intervention where there is Evidence of Neglect

3.1 For the few PRU pupils audited who were currently involved with social services, teenage neglect was a key feature. This manifested as poor hygiene, recurring infestations, a lack of access to dental care, or a lack of parental interest or concern in their well being. Many of these concerns were ongoing and predated their arrival at the PRU—a situation which represents a marked failure of early intervention services and indicates long term consequences of delay in intervention.

3.2 Recommendation:
   (a) There must be a clear strategy for early intervention in every LA, not only focusing on the early years, but addressing neglect and maltreatment in the teenage years. This should clarify expectations of children and families social work.

About NCB

NCB’s mission is to advance the well-being of all children and young people across every aspect of their lives. As the leading national charity which supports children, young people and families, and those who work with them, across England and Northern Ireland, we focus on identifying and communicating high impact, community and family-centred solutions. We work with organisations from across the voluntary, statutory and private sectors through our membership scheme and through the sector-led specialist networks and partnership programmes that operate under our charitable status.

April 2012

Written evidence submitted by the Women’s Aid Federation of England

(Women’s Aid)

EXECUTIVE SUMMARY

Women’s Aid is the national domestic violence charity that co-ordinates and supports an England-wide network of over 370 local domestic and sexual violence organisations running over 500 refuge, advocacy and outreach services and providing direct support to over 300,000 women and children every year as well as online support and services. Women’s Aid is responding to this Inquiry from the perspective of these service users, and in the light of responses to our special survey of community services conducted in 2010.

Women’s Aid welcomes the Education Committee’s commitment to building on the Munro review and the Field, Allen and Tickell Reviews and believes that there is real opportunity to protect children in England from harm. All children have a right to a life free from violence—Article 19 of the Convention on the Rights of the


228 Matching Needs and Services: An audit of the needs of 268 children attending Pupil Referral Units in 4 local authority areas (Liz Brown, NCB, May 2011).
Child, which the UK has ratified, says that all children have the right to be protected from being hurt and mistreated, physically or mentally. Governments are obliged to take all necessary steps to ensure that children and young people can live a life free from all violence.

**Summary of the Issues**

**Violence against Women and Girls (Children) and the Impact**

International and national research shows that the prevalence of Violence against women and girls to be massive. A snapshot examination of the figures shows that:

— Every year 1 million women experience at least one incident of domestic abuse—nearly 20,000 women a week.\(^{229}\)

— At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the “at risk” register live in households where domestic violence occurs.\(^{230}\)

— 3.7 million women in England and Wales have been sexually assaulted at some point since the age of 16.\(^{231}\)

— 33% of girls aged 13–17 who are in an intimate partner relationship have experienced some form of sexual partner violence.\(^{232}\)

— In 2009 the Forced Marriage Unit received over 1,600 calls to its helpline on suspected incidences of forced marriage, 86% of who were women.\(^ {233}\)

— It is widely quoted that there are around 12 so-called “honour” killings a year.\(^ {234}\)

— In 2003, there were up to 4,000 women trafficked for sexual exploitation in the UK.\(^ {235}\)

— 20% of women say they have experienced stalking at some point since the age of 16.\(^ {236}\)

— An estimated 66,000 women in England and Wales in 2001 had been subject to female genital mutilation.\(^ {237}\)

— Almost one in three girls have experienced unwanted sexual touching at school.\(^ {238}\)

**Prevention work in schools**

The impact of violence against women and girls on children’s safety, and hence on the child protection systems, can largely be addressed through the prevention of violence against women and girls through education. It is estimated that violence against women and girls costs society £40 billion each year.\(^ {239}\)

The direct cost to the economy of domestic violence alone in England and Wales in one year is £6 billion. As such, investing in the prevention of violence against women and girls has a massive cost benefit associated with violence in the long term.

Schools provide an opportunity to reach children and young people from an early age to educate them about domestic violence including forced marriages and honour-based violence and they also provide an opportunity for those with positions of responsibility to register where children are at risk of violence including forced marriage.

Children and young people have themselves highlighted the need for clear information and appropriate responses and results of the *Kidspeak* consultation carried out by Women’s Aid have reinforced this and further highlighted that teachers and the education system are a vital support mechanism for children and young people where teachers have the appropriate information.

**Effective protection for victims of domestic violence and their children**

Women’s Aid believes that all children have a right to contact with both parents and all family members as long as it is safe, but that the safety of the children and their non-abusing parents must be ensured.


\(^{230}\) Department of Health (2002), *Women Health into the Mainstream*, London: DH.

\(^{231}\) As above.


\(^{238}\) End Violence Against Women and Yougov poll of 16–18 year olds (October 2010).

To facilitate this, Women's Aid believes that in every case in the family courts, there should be a full risk assessment and management; that wholly independent advocacy should be provided for children in all cases, enabling their views to be fully taken into account; and that there is no assumption that all parents—whether or not they are violent—are good parents.

We also recommend that the family courts recognise the dynamics of domestic violence, including the fact that domestic violence does not start or end at separation and can often continue long after a couple have separated; and that contact may be used as a method of re-victimising survivors and their children.

There is a dangerous separation between the proceedings of three separate court systems: child protection cases under public law (where the focus is on the child, and the mother is encouraged—or even forced—to leave her partner to protect her children from the consequences of living with domestic violence; the criminal court, where the perpetrator is charged and may be convicted of assault, harassment or other abuse; and the family court system where the same abuser is seen as a “good enough father” to be given contact. To avoid the “3 planets effect”, where there are ongoing criminal or child protection proceedings, Women’s Aid recommends these should be taken into account in assessing any risks involved in contact.

CAFCASS

Research and practice has shown that the vast majority of cases that CAFCASS deal with involve allegations of domestic violence. A range of research and inspection reports has also found that there are some examples of very good practice but also examples of extremely dangerous practice which highlight that there is an inconsistency and systematic failure to implement policies and practice relating to domestic violence.

Women’s Aid regularly consults with our members about the effectiveness of CAFCASS and has found that there are still concerns about their effectiveness and also about their understanding of the dynamics of domestic violence. Women’s Aid also has concerns about CAFCASS’ professional bias and discrimination towards Women’s Aid member organisations.

Women’s Aid and the Inter-disciplinary Alliance for Children have concerns that CAFCASS’ current operating priorities mean that there are unacceptable backlogs in cases as well as a lack of continuity of care due to delays.

1. INTRODUCTION

1.1 Women’s Aid Federation of England (Women’s Aid)

1.1.1 Women’s Aid is the national domestic violence charity that co-ordinates and supports an England-wide network of over 370 local domestic and sexual violence organisations running over 500 refuge, advocacy and outreach services. Keeping the voices of survivors at the heart of its work, Women’s Aid campaigns for effective legal protection and services, works to prevent abuse through public awareness, education and training and provides vital 24 hour lifeline services through the 24 Hour National Domestic Violence Helpline (in partnership with Refuge), and through Women’s Aid’s online information and support services for adults www.womensaid.org.uk, and for children and young people, www.thehideout.org.uk.

1.1.2 Women’s Aid welcomes this Inquiry into the Child Protection System and the opportunity to provide written evidence to the Education Select Committee on behalf of our national network of local services, providing local refuge and outreach support to almost 125,000 women and nearly 55,000 children seeking safety from domestic violence in 2009–10. Our forthcoming Annual Survey for 2010–11, which will be published in February 2012, will also give details of the numbers of male victims supported by our services. Nationally we received over 149,000 calls for telephone support in 2009–10 and over 70,000 people a month access our online support services. In 2009–10 there were almost 200,000 page views on Women’s Aid’s dedicated website for children and there are almost 6,000 members of the messageboard.

1.1.3 International research shows consistently that one in four women are likely to experience domestic violence in their lifetime and in England and Wales alone, 3/4 million children are affected by domestic. Two women a week are killed by a current or former partner as a result of domestic abuse. Statistics related to child deaths linked to domestic abuse are not kept but evidence from both the USA and the UK suggests that there is a high correlation: for example, one study of 163 child homicides in 83 different local authority areas in the UK found that there was a background of domestic violence in 46% of these; and an analysis of serious case reviews found that in two-thirds of families where there was child death or serious injury, there was a background of ongoing domestic violence.

1.1.4 In 29 Child Homicides, Women’s Aid compiled a list of 29 children (in 13 families) who were killed as a result of contact or residence arrangements in England and Wales during the previous decade to

240 Professor Marianne Hester and her colleagues likens this to three separate and non-communicating planets: see Radford, Lorraine and Hester, Marianne (2007) Mothering through domestic violence (London: Jessica Kingsley Publishers).
241 Channel 4 despatches child homicide study (July 2009).
and 1 in 4 of all crimes of violence reported were domestic violence. It also found that 1 in 4 of all crimes of violence reported were domestic violence. However, this figure is likely to be a gross underestimation due to the fact that many women do not report domestic violence to the police or take a long time to do so. A study conducted in 1997 found that, on average, women experience 35 incidents of abuse before contacting the police. In families where domestic violence occurs, children witness about three-quarters of the incidents and around half of the children will themselves experience abuse.

Children experience as much abuse in their intimate relationships as adults, with several studies showing that up to 40% experience abuse, physical abuse, financial abuse, emotional abuse and psychological abuse. However, there is a lack of recognition of the seriousness of teenage relationships because they are more likely to be short-lived. This does not mean that they can not be as abusive as adult relationships—in fact research has shown that teenagers experience as much abuse in their intimate relationships as adults, with several studies showing that up to 40% experience abuse. A study by the NSPCC and Bristol University questioned 1,353 young people (aged between 13 and 17 years old) on violence in their intimate relationships found that 33% of girls and 16% of boys reported some form of sexual abuse; 25% of girls (the same proportion as adult women) and 18% of boys have been physically abused.

A snapshot survey of domestic violence taken on one day (Thursday, September 28, 2000) showed that every minute in the UK, the police received a call asking for assistance with domestic violence.

2. Summary of Key Issues

2.1 Violence against Women and Children and the Impact

Women's Aid believes that no discussion of child protection in England can be conducted without looking at the disproportionate impact of violence on women and children, and especially girl children.

The Department of Health estimates that every year almost 750,000 children experience domestic violence. However, this figure is likely to be a gross underestimation due to the fact that many women do not report domestic violence to the police or take a long time to do so. A study conducted in 1997 found that, on average, women experience 35 incidents of abuse before contacting the police. In families where domestic violence occurs, children witness about three-quarters of the incidents and around half of the children will themselves have been physically abused.

A snapshot survey of domestic violence taken on one day (Thursday, September 28, 2000) showed that every minute in the UK, the police received a call asking for assistance with domestic violence.

Teenage relationship abuse, a child protection issues in itself, consists of the same patterns of coercive and controlling behaviour as domestic abuse. These patterns might include some or all of the following: sexual abuse, physical abuse, financial abuse, emotional abuse and psychological abuse. However, there is a lack of recognition of the seriousness of teenage relationships because they are more likely to be short-lived. This does not mean that they can not be as abusive as adult relationships—in fact research has shown that teenagers experience as much abuse in their intimate relationships as adults, with several studies showing that up to 40% experience abuse. A study by the NSPCC and Bristol University questioned 1,353 young people (aged between 13 and 17 years old) on violence in their intimate relationships found that 33% of girls and 16% of boys reported some form of sexual abuse; 25% of girls (the same proportion as adult women) and 18% of boys have been physically abused.

Women's Aid also provides specialist training on domestic violence for professionals within the family justice system. We have worked closely with Skills for Justice to develop their specialist National Occupational Standards (NOS) for Domestic and Sexual Violence and we also run a National Training Centre with Accredited Training for all professionals on domestic and sexual violence. We also work closely with our sister Federations in Northern Ireland, Scotland and Wales on issues relating to the family justice system.

To ensure that our response reflects not only previous evidence and research but the current perspective and evidence from our network of member services, we also carried out a number of surveys in 2010/11 of our members on some of the issues related to the Inquiry, including for the Family Justice Review and a survey examining the impact of Local Authority cuts on our services’ ability to protect children and young people from domestic violence. We have also included consultations held with our members over the period 2008–11 on the work of CAFCASS which is attached at Appendix 1.

2.1.1 Women’s Aid believes that no discussion of child protection in England can be conducted without looking at the disproportionate impact of violence on women and children, and especially girl children.
reported some form of physical relationship abuse and around 75% of girls and 50% of boys reported some form of emotional relationship abuse.250

Pregnancy is often a time when domestic violence either starts or escalates. It has been referred to, by one commentator, as “double-intentioned violence” as physical attacks directly affect both the mother and the unborn child.251 The Confidential Maternal and Child Health Enquiry in England and Wales indicated that 39% of women experienced domestic abuse during pregnancy (n=70) and that 19 of the women died as a direct result of the abuse.252 The Enquiry also found that 81% of women found it difficult to access ante-natal services; 77% were in contact with their local social services; 64% of mothers and children were in contact with child protection services and that 62% of pregnant women under the age of 18 had experienced domestic violence in the home.253 An Australian population survey showed that 41% of women who experienced domestic abuse reported violence during pregnancy, and that 20% of these women who experienced domestic abuse reported that their first experience of violence was during pregnancy.254 There is also a very strong link between pregnancy and domestic violence255 with one study showing that women who were subjected to domestic violence in pregnancy were four times more likely to miscarry than women who had not been abused during pregnancy.256 Studies have also found that that pregnancy is a time of increased risk with a significant association between pregnancy, miscarriage, low-birth rate and poor mother-child attachment or physical or sexual violence;257 abused women have said that they are more likely to be kicked in the abdomen or breasts during pregnancy.258

Children can be adversely affected by domestic violence in one of two ways. They can be indirectly abused by the perpetrator by witnessing violence to their mother or they can be directly abused themselves by the perpetrator (physically, sexually, emotionally, financially or psychologically).

Indirect Abuse

Most children are aware of the violence and the abuse suffered by their mothers from a very early age.259 The research also showed that most children are aware of the violence and abuse suffered by their mothers—87% of the 108 mothers in the study believed that their children had witnessed or overheard the abuse. This mirrors earlier findings which show 90% of children are in the same or adjoining rooms when domestic violence occurs.260

Section 120 of The Adoption and Children Act 2002 extended the legal definition of “significant harm” to a child to include the impairment suffered from seeing or hearing the ill treatment of another—particularly in the home, even if they themselves had not been physically abused or assaulted. The amendment which came into effect in January 2005 was created in response to research that children can suffer long-term damage from living in a home where domestic violence is taking place.261

Direct Abuse

In families where domestic violence occurs, children may also be sexually or physically abused. A meta-analysis of research studies estimated that in 30–60% of domestic violence cases, the abusive partner was also abusing children in the family.262 The rate of reported domestic violence is particularly affected by whether active questions are asked about abuse of children. A study of NSPCC cases found that where children were known to have been abused there was a dramatic increase in disclosure of abuse from an initial one-third to two-thirds of children, once a domestic violence monitoring form was introduced.263

253 Ibid.
261 See note 22 above.
A 2002 NSPCC prevalence study showed that 26% of 18 to 24 years olds had lived with violence between their parents/carers and for 5% this was frequent and on-going.\textsuperscript{264}

In a 1994 study of women and children who had left an abusive situation, 10% of mothers had been sexually abused in front of their children and 27% of the partners had also abused the children.\textsuperscript{265}

2.1.3 Children and young people can be extremely affected by their experiences of living with domestic violence. The impacts can be physical, behavioural, psychological or educational and they can also be long-term or short-term impacts.\textsuperscript{266} The way that children can be impacted depends on a wide range of factors including: age and developmental stage, gender, ethnicity, position within the family, sexuality, disability, their relationship with their mother, whether the abuse was direct or indirect, their access to safety and existence of support networks:

Children exposed to sudden, unexpected man-made violence appear to be more vulnerable—making the millions of children growing up with domestic violence...at great risk for profound emotional, behavioral, physiological, cognitive, and social problems.\textsuperscript{267}

Physical\textsuperscript{268}

Children and young people can be hurt, either by trying to intervene and stop the violence or by being injured themselves by the abuser. They may develop self-harming behaviour, or eating disorders. Their health could also be affected as they may not be being cared for appropriately (perhaps due to the mother’s not being allowed to parent correctly by the abuser). They may have suicidal thoughts or turn to self-harm or try to escape the violence through misuse of alcohol or drugs, truanting or by running away.

Sexual

There is a high-risk that children and young people will be abused themselves where there is domestic violence. In homes where living in fear is the norm, an atmosphere of secrecy can develop and this creates a climate in which sexual abuse could occur. In addition to this, children may sometimes be forced to watch the sexual abuse of their mother. This can have a long-lasting impact on the sexual and emotional development of the child.

Economic

The mother of the child may have limited control over the family finances. Therefore, there might be little or no money available for extra-curricular activities, clothing or even food which can have a detrimental impact on their health and development. It may also mean that children who go into refuge provision have to leave behind personal possessions, including toys, books, computers and so on which cannot easily be replaced due to lack of money. Separation can also lead to poverty for many mothers and children, especially if mothers deem that fighting their ex-partner for their house or possessions may adversely affect their safety.\textsuperscript{269}

Emotional

Children will often be very confused about their feelings. They may, for example, love both parents but want the abuse to stop. They may be given negative messages about their own worth, which may lead to low self-esteem or depression. Many children feel guilty and believe the abuse is their fault. Some children may internalise feelings and appear passive and withdrawn whilst others externalise their feeling in disruptive behaviour.

Isolation

Children may become withdrawn and isolated. They may not be allowed out to play by the perpetrator and if there is abuse in the home, they are less likely to invite their friends around. Schooling may be disrupted by a variety of factors including: being too scared to leave their mother alone or they may have had to move schools when they moved into refuge provision or other safe or temporary accommodation.

Threats

Children are likely to have heard threats to harm their mother. They may also have been directly threatened with harm or heard threats to harm their pet. They also live under the constant and unpredictable threat of


\textsuperscript{266} For a detailed discussion of the impact of domestic violence on children see Hester \textit{et al} (2007) \textit{op cit}.


\textsuperscript{268} The impacts detailed below have been adapted from Women’s Aid’s Expect Respect Educational Toolkit, available to download for free from: http://www.womensaid.org.uk/page.asp?section=0001000100280001&sectionTitle=Education+Toolkit

\textsuperscript{269} Abrahams, 1994) \textit{op. cit}. 
violence, resulting in feelings of intimidation, fear and vulnerability, which can lead to high anxiety, tension, confusion and stress.

2.2 Prevention Work in Schools

2.2.1 Research commissioned by the Home Office and cited in the HASC report\(^{270}\) indicated that for domestic violence to be addressed effectively it should at least be a core feature of PSHE. Teachers cannot be expected to deal confidently with relationships without understanding issues such as domestic violence and forced marriage and these issues require specialist training, information and advice.

There is a growing recognition that the home lives of children and young people can have a significant impact on their ability to participate fully in school life and achieve academically.\(^{271}\) Furthermore, children and young people are the next generation of potential victims and perpetrators of domestic abuse.

The current child protection legislation, policies, procedures and guidelines tend to be reactive, rather than proactive, yet by working with children and young people now, Women’s Aid believes that we can prevent domestic violence in the future.

As schools are where children and young people learn how to interact with others, it is an ideal environment in which discriminating attitudes which can underpin abusive behaviour can be tackled.

2.2.2 Schools have a crucial role to play, alongside parents and carers, in helping children and young people to develop respectful relationships, manage their emotions, and challenge the way in which some young men behave towards young women. Schools’ existing statutory duty to develop and implement a behaviour policy, an anti-bullying policy and a gender equality policy gives a strong context for schools to develop their important preventive role in ending violence against women and their role in supporting girls and young women experiencing violence. This work will also contribute to the fulfillment of schools’ and local authorities’ duty to safeguard and promote the welfare of children. Schools can help children and young people understand that no one should be abused (through work on PSHE education, Citizenship and other approaches such as SEAL.

Schools can create an environment which both promotes their belief and commitment that domestic abuse is not acceptable, and that they are willing to discuss and challenge it. There is currently a designated teacher in each school with responsibility for safeguarding children, but these teachers have not been specifically trained to respond to domestic violence.

It is crucial when designing any prevention programme to work in schools that a “whole-school” approach is taken. Women’s Aid has found that young people will not only disclose to teaching staff but are more likely to disclose to someone they trust and this may be anyone who works for the school. A “whole-school approach” means involving everyone in the school including non-teaching staff and school governors to help to prevent abuse in the future.\(^{272}\)

2.2.3 Schools can support their students by:

1. Informing all staff about the school’s child protection procedures and how they relate to domestic violence. They know when to discuss concerns with the designated senior member of staff for child protection and how they can refer young people support services.
2. Displaying Information about local support services in the school. This includes students having access to school counsellors and peer mentors who can provide appropriate support.
3. Referring to External agencies for specific support, including youth justice, police, sexual assault referral centres, children’s social care services and local domestic violence agencies.

Women’s Aid believes that schools should also be inspected by Ofsted, as part of their inspection framework, specifically on their success or failure to address issues contained in the educational toolkit on domestic violence and relationships:

Our experience of working with schools on violence against women and girls identifies a number of key challenges. This includes a lack of capacity within the staff team and the curriculum to develop new areas of work, making a case for prioritising the work, determining where and how best to start developing an action plan. Another key barrier is a general lack of understanding of how gender inequality manifests in school environments, and how prevalent violence against women and girls is in the school and local community. This lack of understanding means that teachers are resistant to delivering work on VAWG as they get scared of “opening a can of worms” and do not understand their existing responsibilities for child protection. Yet, not “opening the can of worms” can result in a more serious incident later where schools may be at risk of not meeting their child protection obligations.

Schools need to embed the work into their policies and frameworks so that it is sustained and linked in.


\(^{271}\) Prevention work is also vital when working in other youth settings including: youth clubs; short-stay schools (formerly pupil referral units) and youth offending teams.

\(^{272}\) The text on developing a whole-school approach has been adapted from Sharpen, J and Wharf, H (2010), Teenage Relationship Abuse: A Teacher’s Guide to Violence and Abuse in Teenage Relationships, London: Home Office.
Training needs to be on delivery of interventions by teachers (facilitation skills) and support services for young people impacted by VAWG (child protection).

2.2.4 Historically the inclusion of the issue of domestic abuse within school lessons has been patchy and inconsistent. In order to address this, Women’s Aid carried out research to identify the barriers facing schools and teachers, with the aim of developing an appropriate and helpful response.

Teachers told us that due to conflicting demands and the pressure to attain academically, there was little time to look through the myriad of resources that exist for schools to find appropriate lesson plans. Women’s Aid response was to create an easy-to-use resource that has simple lesson plans that can be used from reception to year 13.

With funding from The Body Shop, Women’s Aid has developed an online education toolkit, “Expect Respect” that includes:

- An easy to use, one hour lesson plan for each year of school from reception to year 13;
- clear guidance regarding the links between the learning outcomes within the lesson plans and the relevant parts of the Early Years/National Curriculum, SEAL and the Every Child Matters agenda;
- supporting information and resources for teachers;
- additional interactive activities for children and young people to access on line where appropriate; and
- an online support service giving teachers individual advice and guidance about the delivery of the lesson plans.

The lesson plans were developed by experienced teachers in partnership with domestic abuse experts from Women’s Aid. Each lesson plan has been tested in a variety of school settings by teachers not involved in their development, and has then been amended in light of this evaluation. Children and young people themselves were also involved in this evaluation, and their valuable feedback has informed the final documents. It has also been evaluated by different agencies and local areas who have chosen to incorporate this work into their schools.

Women’s Aid has also developed an inset training day that can be used to train teachers on domestic violence and how to use the toolkit effectively.

The Expect Respect Educational Toolkit is available for free from Women’s Aid’s website and supporting materials can also be ordered free from our website www.womensaid.org.uk

Women’s Aid is currently undertaking an evaluation of our educational toolkit. This is not a rigorous research project but a “what works” in local areas. The toolkit was originally designed for work in schools but its remit has expanded to incorporate wider youth settings and youth justice settings, including short stay schools and Youth Offending Teams.

2.2.5 Women’s Aid recommends that The Centre for Excellence in Outcomes (C4EO) should be supported by government to appoint two sector specialists in violence against girls and young women. These appointments would need to be funded centrally. It would ensure that all examples of good practice of prevention and support are recorded, new ones collated and specialist support for local areas is brokered. This would be an excellent opportunity for local areas to support other areas with practical advice and support and develop community responses that work across a wide range of local authorities.

2.2.6 There is also a chronic under-resourcing of children’s services for working on violence against women and girls. For example, a Women’s Aid survey of child support workers found that 80% of them are under pressure due to funding cuts and that almost 90% are under immediate pressure and do not know whether they have funding post March 2011.

Despite this chronic under-resourcing specialist services are working with schools throughout the country to provide specialist expertise on developing appropriate school responses and are also a key referral point for individuals. In order for these services to continue this role and to increase their coverage to ensure that all schools are linked in with specialist services, the government must fill the gaps in funding for these services.

2.3 Effective protection for victims of domestic violence and their children

2.3.1 Women’s Aid’s main concern for the purposes of providing evidence to this inquiry is how the family courts can effectively protect and support families where domestic violence is a factor in family breakdown—divorce, separation, arrangements for children—to ensure the safety of children and parents in both the short and the long-term, whether in the realm of “public” or “private” law.

2.3.2 Domestic violence is one of the greatest family and criminal problems facing the UK, accounting for a quarter of all violent crime. It is a pattern of violence that includes physical, psychological and sexual violence.

273 The Every Child Matters Agenda no longer exists as in government terminology (post-May) although agencies are still using it.

274 Women’s Aid (2010) Children’s Support Workers: A Special Survey; Women’s Aid, National Children’s Supporter Worker Meeting, 26 November 2010.
2.3.3 Women’s Aid is concerned that there is no reference to domestic violence in the current call for evidence. This is particularly striking as evidence has shown that domestic violence features significantly in both private and public law cases.\textsuperscript{275} In our evidence, Women’s Aid has used the definition of the family courts as outlined in the Ministry of Justice Court Statistics,\textsuperscript{276} that the family courts deal with issues such as parental disputes, child protection cases, divorce and separation, and cases of domestic violence. We do not believe that these are mutually exclusive categories and they are interwoven and should be dealt with accordingly by the family courts. The Ministry of Justice’s own figures show that only 10% of divorce and separation cases come into the family justice system, but of those, research has shown that a high proportion involve unreasonable behaviour from one of the parties including physical and mental abuse, often severe abuse, and this abuse also affects children significantly; often this abuse often continues long after separation has occurred.\textsuperscript{277} Equally, 75% of children on child protection registers are affected by domestic violence in their family.

2.3.4 There is a dangerous separation between the proceedings of three separate court systems: child protection cases under public law (where the focus is on the child, and the mother is encouraged—or even forced—to leave her partner to protect her children from the consequences of living with domestic violence; the criminal court, where the perpetrator is charged and may be convicted of assault, harassment or other abuse; and the family court system where the same abuser is seen as a “good enough father” to be given contact.\textsuperscript{278}

2.3.5 Our particular concern is outcomes of applications for contact and residence and the subsequent safety of children and non-abusing parent following these.

2.3.6 Women’s Aid believes that all children have a right to enjoy regular contact with both parents and family members, following separation, provided that it is safe. Furthermore we believe that there is a link between equality and respect in family relationships and the incidence of domestic violence. Not only is there an obvious historical link in our own country’s history in the status of women and access to better human rights, but we can still see in countries where there is absence of gender equality, and women’s status is significantly lower, much higher incidences of violence against women and children.

2.3.7 Put another way, equality between women and men, in all aspects of life, including responsibilities for care and nurture of children, by providing better role models of healthy relationships for children and young people, for girls and for boys, is likely to help prevent violence and bullying behaviour in private and family life in the future.

2.3.8 For that reason we do believe that, except where there is a risk to their safety or wellbeing, where relationships have broken down, children should be able to have contact with non-resident parents, with grandparents, or be looked after through shared parenting arrangements.

2.3.9 However, where there is domestic violence, the family justice system should not assume that contact is beneficial and should be rigorous in the management of risks to safety and well-being of children and their parents. As Lord Justice Wall, now President of the Family Division, has said we should continue to promote the message that it is not possible at one and the same time to be guilty of serious violence to your partner and to hold yourself out as a good parent. The old approach that a man may have abused the mother of his children, but that he had not struck the children and that he was still a good father will no longer wash in the overwhelming majority of cases.\textsuperscript{279}

2.3.10 Women’s Aid firmly believes that in every case in the family justice system, especially where there are allegations of children witnessing or experiencing abuse, that there needs to be separate, wholly independent advocacy for children. Women’s Aid frequently carries out consultation and research with children and young people to get their views on all elements of our work. In our Kidspeak report in 2007,\textsuperscript{280} children expressed their wish for independent advocacy and representation and were extremely concerned that their views were not considered as they should be.

2.3.11 Women’s Aid recommends:

\begin{itemize}
  \item That effective protection of children and their non-abusing parent in both the short and long term be the primary consideration of the family justice system.
  \item That there is no assumption that a violent parent is a good parent or that they have stopped being abusive just because they say that they have.
\end{itemize}

\textsuperscript{275} For example, in a 2008 study conducted by the Ministry of Justice into applications for child contact orders, in 54% of cases sampled, the resident parent raised concerns over serious welfare issues, 34% of which were related to domestic violence. See Hunt, J and Macleod, S (2008), Outcomes of applications to court for contact orders after parental separation or divorce, Briefing Note, Ministry of Justice, Family Law and Justice Division, September 2008.

\textsuperscript{276} Ministry of Justice (2010), Court Statistics Quarterly: January to March 2010, Ministry of Justice Statistical Bulletin.


\textsuperscript{278} Professor Marianne Hester and her colleagues likens this to three separate and non-communicating planets: see Radford, Lorraine and Hester, Marianne (2007) Mothering through domestic violence (London: Jessica Kingsley Publishers).

\textsuperscript{279} Lord Justice Wall (2007) Domestic Violence in Consent Orders, in a speech to the Hertfordshire Family Forum at the Law Faculty of the University of St Albans on 13 March 2007, available at: http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhaff/263/263we49.htm

\textsuperscript{280} Barron, J (2007), Kidspeak: Giving Children and Young People a Voice on Domestic Violence, Bristol: Women’s Aid.
— That the family justice system recognises that domestic violence neither begins nor indeed stops, at the point of separation and can often continue long after separation.
— The views of children are fully taken into account in line with international commitments.

2.4 CAFCASS

2.4.1 A 2002 NAPO survey on the work of CAFCASS found that, of 300 cases involved, 77% (230 cases) featured allegations of domestic violence.\(^{281}\) In 2005, Her Majesty’s Inspectorate of Court Administration (HMICA)\(^{282}\) published a fairly damning report on the work of CAFCASS. The report, whilst stating that there was some excellent practice by CAFCASS, was highly critical of overall practice and made eleven main recommendations for change including providing further training for CAFCASS staff on domestic violence. The CAFCASS response to the report was to produce a Domestic Violence Toolkit\(^{283}\) in 2005, which was updated in 2007. The Toolkit advises that even when contact is felt to be in the interests of the child, the safety and protection of the child and the abused parent must be paramount (CAFCASS, 2007:55).

2.4.2 Women’s Aid consultation with our member services, through telephone consultations between 2008 and 2010, has also shown that in local areas, CAFCASS has mixed practice ranging from really excellent services for children to extremely poor and unsafe practice. Some of the highlights of this research can be found in Appendix 2.

2.4.3 However, recent inspections of CAFCASS by Ofsted including a follow-up inspection in the South East region in 2008 have still raised concerns about the role of CAFCASS in private law cases. The 2008 report\(^{284}\) found key faults indicating that CAFCASS personnel still, in some cases, needed additional training on domestic violence and contact.

2.4.4 Women’s Aid has serious concerns about the effectiveness of CAFCASS and is a member of the Interdisciplinary Alliance for Children, and support the statement issued in July 2010. The main concerns flagged by the group are:
— There are unacceptable backlogs of cases in public and private law proceedings, despite the commitment and best efforts of front line staff who have been working under great pressure for a considerable length of time.
— CAFCASS’ current operating priorities are now posing a serious threat to the statutory framework of children’s rights and evidence-based health and welfare policies, painstakingly developed through research and clinical practice over some forty years. Two examples of this are the proposed amendment of s.41 Children Act 1989—opposed by twenty two interdisciplinary organisations in 2009—and a recent legal note circulated by CAFCASS which purports to give it authority to make changes to the section 41 roles and responsibilities of the children’s guardian.
— From August 2009 CAFCASS has been on an emergency footing and has only been able to offer “a minimum safe standard” of service delivery. A gap has opened up between organisational definitions of what constitutes a “safe minimum” and the statutory duty to give paramount consideration to the best interests of the child. Practitioners are concerned that in complying with organisational directives they may potentially be in breach of both their statutory duties and their professional code of ethics.
— The assumption that appears to underlie operational decision-making and resource allocation within CAFCASS is that what is best for CAFCASS as an organisation will also be best for children. This is debatable and currently not evidence-based.
— CAFCASS has become increasingly bureaucratised and this is impeding the proper exercise of the professional discretion of its practitioners.
— The framework of inspection applied by OFSTED does not appear to be fit for purpose.

2.4.5 Women’s Aid also has concerns that some CAFCASS officers do not, as previously stated, have sufficient training on domestic violence to understand the power and control relationship that exists between the abusing and non-abusing parent. We also have evidence that our member services have experienced professional bias and discrimination from some CAFCASS officers—these CAFCASS officers do not recognise that Women’s Aid Services are professional specialist services (required and assessed under the Government “Supporting People” Quality Assessment Framework. Our member services have also flagged the delay and backlog in cases which makes it difficult for continuity of care from CAFCASS officers.

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\(^{281}\) NAPO, (2002) Contact, Separation and the work of Family Court Staff: A Briefing, NAPO the Trade Union and Professional association for Family Court and Probation Staff.


APPENDIX 1

RESULTS OF TELEPHONE CONSULTATIONS ON CAFCASS 2008–2011

1. INTRODUCTION AND METHODOLOGY

In support of our submission, Women’s Aid (WA) has gathered together research and consultation that we have carried out with our member services during the period 2008–11.

The research from the consultations was used to inform Ofsted during their area inspections of CAFCASS and the geographical areas used in the research correspond to the CAFCASS service areas.

The comments have been grouped together in thematic areas, with the underlying premise of an examination of their effectiveness in child protection:

— General Comments.
— Training.
— Service user engagement.
— Listening to children.
— Partnership working.

2. SUMMARY OF KEY RESPONSES

General Comments

Generally, we have received mixed reviews from our members about CAFCASS. In some areas they seem to be working extremely effectively and are sympathetic and understanding towards victims of domestic violence whilst in other areas they are extremely poor and appear almost hostile towards the women in our services. Many of the respondents also noted the time delays, including time delays in cases where the original CAFCASS worker was on long-term sick leave and had not been replaced.

Case Study Example: C7 Area (Cheshire and Merseyside)

We had one case in particular, a woman who had severe mental health illness (bi-polar disorder). She had several appointments with him [the worker in question], as she had been forced to flee her marital home and leave her children behind. She was especially vulnerable due to the extent of her mental health difficulties, and required heavy levels of support from us. He refused to let her take an advocate from our organisation into the appointments with her. We used to transport her there, but he would not allow us in with her. We had to wait outside until the appointment was over.

She found this quite an ordeal and left every appointment very distressed, stating that he had been horrible to her.

Since then I have attended a workshop at National Conference, facilitated by CAFCASS personnel, who assured me that he was in the wrong to do this, as it was her human right to have someone in the appointments with her if she chose to. The woman in question at the time did not want us to take any action, as she was still dealing with CAFCASS and trying to win the right to see her children. She feared that “making trouble” for him would have a detrimental outcome on her case.

Training

CAFCASS have developed an excellent training course on domestic violence for their workers but what Women’s Aid members have told us is that its implementation is patchy and inconsistent and that many of the workers do not understand the dynamics of domestic violence. Many of our respondents told us that CAFCASS can often side with the “charming” father and believe that he is going to change his behaviour because he has said so. We also have evidence of CAFCASS spending the majority of their time with the father and not with the mother and also interviewing the father and child together but not the mother and child. There are also reports from our members that CAFCASS also do not understand that perpetrators of domestic violence can be extremely manipulative.

Our members believe that CAFCASS workers need more training and that when they do receive it, or where there are mutual training days (see partnership working below) they develop a better understanding and are more likely to be objective in their reports:

“There is no deeper investigation into the cases—often what is said by the father is taken at face value”.

“The CAFCASS officers still do not have an understanding of the dynamics of domestic violence”.

“There is little understanding of abuse and its impact on women and children”.

“In (Y-town) I think there is only one good worker. She is the only one that has any grasp of dv. Yet this worker still made a comment to the mother [who had experienced severe domestic violence] on interviewing the child by saying “oh I see he gets his looks from his father”.

“They have no understanding of domestic violence. They don’t realise how manipulative perps can be”.
Case Study Example: N3 Area (Lancashire and Cumbria)
— In this case it was the mother seeking contact (she has since suspended/withdrawn the case) as she had fled the abuser but could not take the boy with her (I am unsure whether it was due to ages of boys allowed in the refuge or if it was a speed of fleeing issue).
— The DV had a profound effect on the boy and he had attempted suicide twice. He was also seen to be very attached to his mother.
— He said he did not want to see his mother and started using language that mirrored the language that the father used (eg slag and slut etc).
— The father had exerted a lot of pressure on the boy to say that he did not want to see his mother.
— The mother had had an affair and the boy knew all of the details about this (which he could not have done unless the father had told him).
— The officer took on board what the boy said completely without probing deeper into the family situation and into how the boy knew all of the details.
— They also neglected to interview the other son, who was 18/19 who said that the father had told the younger brother about the affair.
— In this case the boy had clearly been manipulated by the father but the CAFCASS officers did not pick this up.

Case Study Example: N4 Area (North and East Yorkshire and Humberside)
One of the children, who is 11, is displaying behavioural problems including violence against his male siblings and the mother. The father is encouraging the child’s behaviour against the mother.
The CAFCASS worker was assigned again to look into the case but the date for her report has already passed. She has yet to contact any outside agencies and the final hearing is in November.
She has seen the children, but with the father present and no permission from the mother who has residency. She has spent huge amounts of time with the father but none with the mother (which I feel is typical of CAFCASS in this area).
In court, the CAFCASS worker sat with her solicitor and gave him a huge list of questions to ask the mother, almost as if she were cross-examining the mother and challenging her evidence but she did not have any questions for the father.
She has no experience or understanding of dv. In general in the York area the workers have no understanding of perpetrators (ie that they come across as charming and are v manipulative). They appear to take what they say at face value. They also have poor knowledge of the impact of dv on families and children. There is also little empathy for the mothers.
It is also clear where the father is educated and middle class they tend to take his side and be very pro-contact, regardless of what the children say.

Service User Engagement
As outlined above, many of the issues around service user engagement are linked to a lack of thorough training on domestic violence. In some areas CAFCASS can appear quite hostile towards women according to our member services, whilst in others our members were very positive about CAFCASS’s attitudes towards women especially if they were in refuge provision.
“Once they know they [the women in their service] have been in refuge they are very sympathetic. They acknowledge that it is very difficult for them”.

“The use of male officers is still a cause for concern for many of the women as they are very reluctant to disclose the full levels of violence, especially sexual violence and this means that often the workers don’t think that the domestic violence is as bad as it is. This causes concern because women feel they are unable to present their case as fully as possible”.

“We have too many examples of times that domestic abuse is minimised. There is a lot of sympathy for the dads and admiration that they want to see their children. Past domestic violence is dismissed as they are keen for everyone “to move on”. Current abuse is minimised and even when noted, seen as something he should try to moderate but not dealt with seriously. Mums are put under a lot of pressure at court to put their needs aside in order to accommodate dad”.

Listening to Children
The message is clear here—CAFCASS in most (but not all) of the areas that we consulted do not adequately listen to the voices of children. We have clear evidence where children have clearly said they do not want any contact with their father but yet CAFCASS recommend that contact takes place.
“They are still not listening to the children as much as they should do”.

“In another case, the client asked the WA worker to go with them for their CAFCASS interview. The CAFCASS worker refused to allow WA to be present. This case was originally in an outreach service but the
mother and the child are so terrified that they entered into refuge provision. The child who is 7/8 is so terrified of her father that she does not want any contact with him. CAFCASS did not take this seriously”.

Case Study Example: N3 (Lancashire and Cumbria)

— In this case a 14 year old girl wanted no contact with her father, that she had no interest in maintaining relations with him.
— The mother said that she did not mind if the father had contact but that it was up to the daughter.
— The CAFCASS officer said that the mother was clearly manipulating the daughter into saying that she did not want contact and recommended that contact be awarded.
— This was also a case that had been to MARAC so was obviously high risk.

Partnership Working

There are mixed levels of engagement by CAFCASS with Women’s Aid members. In some areas CAFCASS work very effectively and value Women’s Aid members’ input into their report whilst in other areas CAFCASS will not even talk to our members and view them as not being of importance or of a professional level.

“CAFCASS are happy to engage and the manager of CAFCASS (although she is leaving I think) works with the manager of WA”.

“Hull Women’s Aid and CAFCASS have a very good working relationship. The workers appear to have good knowledge of DV and WA has no concerns about them”.

“We have tried to build bridges with CAFCASS by inviting them for mutual training and information. This has been cancelled on a number of occasions”.

“CAFCASS do not attend the local dv forum which I feel is not a tokenistic forum, as in other areas, but is very well attended by all other agencies (health, police, social services, local council etc.) CAFCASS’s non-attendance has been raised on more than one occasion at the forum but they appear unwilling to engage. They need a cultural shift not just training”.

“CAFCASS tell the service when they are involved and ask for recommendations from the service on what they should do—they use our existing relations with the children to consult their views. They ask us to ask the children (and in our own opinions) whether there should be contact and at what level (supervised, unsupervised, overnight etc) we are also asked to prepare court reports for CAFCASS on the children’s views”.

“We have had no response to any complaints made and feel that no changes have been made to CAFCASS as a result of our complaints.”

April 2012

Further written evidence submitted by the Women’s Aid Federation of England

(Women’s Aid)

EXECUTIVE SUMMARY

Women’s Aid is the national domestic violence charity that co-ordinates and supports an England-wide network of over 370 local domestic and sexual violence organisations running over 500 refuge, advocacy and outreach services and providing direct support to over 300,000 women and children every year as well as online support and services. Women’s Aid is responding to this Inquiry from the perspective of these service users.

Women’s Aid welcomes the Education Committee’s commitment to building on the evidence received to date on child protection and to extend their Inquiry to gather evidence on neglect; older young people and thresholds for intervention.

SUMMARY OF THE ISSUES

1. Neglect

Neglect is defined by the Government as:

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. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

1. provide adequate food, clothing and shelter (including exclusion from home or abandonment);
2. protect a child from physical and emotional harm or danger;
3. ensure adequate supervision (including the use of inadequate care-givers); and

4. ensure access to appropriate medical care or treatment.

According to child protection statistics, out of 42,700 children and young people who were the subject of a child protection plan in 2011, 18,700 were directly subject to a plan due to neglect. The NSPCC also found, in their 2011 Child Maltreatment study, that neglect was found to be the most prevalent type of maltreatment in the family for all age groups. 5% of children under 11, 13.3% of 11–17 year olds and 16% of 18–24 year olds had been neglected at some point in their childhoods.

Neglect, like other forms of abuse, can cause lasting impacts on children and young people which without proper support and protective factors, can lead to long-term consequences. Persistent neglect can lead to serious health and development difficulties and delays, and long-term problems with social functioning, relationships and educational delay. In extreme cases, neglect can also result in death.

2. Older Young People

Research in the UK has shown consistently that up to 40% of teenagers experience domestic violence in their own right and yet the response from statutory bodies has been poor with many services not recognising that there are significant child protection implications for this group of young people. Feedback from services in our national network shows that there is unmet need in relation to provision of safety and support planning for young women survivors of teenage domestic violence and a need for provision of age appropriate prevention programmes for teenage perpetrators (mainly boys). This is urgent, especially as more evidence emerges that pornography accessing via the internet is informing sexual practices in teenage relationships and in some cases placing unrealistic expectations of sexual behaviours that may be abusive or harmful on young people in teenage relationships.

10% of the young women directly supported in refuge by Women’s Aid member services in 2009–10 were aged between 16–20 years old and a further 3% were young people known to be escaping forced marriage.

3. Thresholds

Women’s Aid has gathered evidence over our 35 year history of women who have had children taken into care because they have been experiencing domestic violence. Rather than supporting the women and children to escape the abuse or to remove the perpetrator, social services removes the children from the mother. It is vitally important that social services hold perpetrators to account and take steps to manage the risk that they pose to both mothers and to their children and ensure that perpetrators are referred to appropriate perpetrator programmes.

Response of the Women’s Aid Federation of England (Women’s Aid)

INTRODUCTION

Women’s Aid Federation of England (Women’s Aid)

1.1.1 Women’s Aid is the national domestic violence charity that co-ordinates and supports an England-wide network of over 370 local domestic and sexual violence organisations running over 500 refuge, advocacy and outreach services. Keeping the voices of survivors at the heart of its work, Women’s Aid campaigns for effective legal protection and services, works to prevent abuse through public awareness, education and training and provides vital 24 hour lifeline services through the 24 Hour National Domestic Violence Helpline (in partnership with Refuge), and through Women’s Aid’s online information and support services for adults www.womensaid.org.uk, and for children and young people, www.thehideout.org.uk.

1.1.2 Women’s Aid welcomes this Inquiry into the Child Protection System in England and the opportunity to provide written evidence to the Committee on behalf of our national network of local services, providing local refuge and outreach support to almost 125,000 women and nearly 55,000 children seeking safety from domestic violence in 2009–10. Our forthcoming Annual Survey for 2010–11, which will be published in 2012, will also give details of the numbers of male victims supported by our services. Nationally we received over 149,000 calls for telephone support in 2009–10 and over 70,000 people a month access our online support services. In 2009–10 there were almost 200,000 page views on Women’s Aid’s dedicated website for children and there are almost 6,000 members of the messageboard.

1.1.3 Research shows that in England and Wales alone, 3⁄4 million children are affected by domestic abuse. Statistics related to child deaths linked to domestic abuse are not kept but evidence from both the USA and
the UK suggests that there is a high correlation: for example, one study of 163 child homicides in 83 different local authority areas in the UK found that there was a background of domestic violence in 46% of these, and an analysis of serious case reviews found that in two-thirds of families where there was child death or serious injury, there was a background of ongoing domestic violence.  

1.1.4 In 29 Child Homicides, Women’s Aid compiled a list of 29 children (in 13 families) who were killed as a result of contact or residence arrangements in England and Wales during the previous decade to 2004 (however, since there are no national statistics kept on this, the actual figure may be higher). Ten of these children were killed between 2002 and 2004. With regard to five of these families, contact was ordered by the court. The publication of 29 Child Homicides raised the profile of child contact and the risks that unsafe child contact can pose to both the child and the non-abusing parent (usually the mother).

1.1.5 Women’s Aid has a two-fold role within the child protection system. At a local level our network of over 500 services provides specialist advocacy and support to women and children, including those involved in the child protection system. At a national level we work right across the voluntary and statutory sector to provide specialist advocacy for all children and women affected by domestic violence in England. We work, at a national level, with a wide range of Government departments and external agencies to ensure that all children and women are safe. We also sit on a range of multidisciplinary groups including the Department for Education’s Violence Against Women and Girls (VAWG) Advisory Group; the Children are Unbeatable Alliance and the Inter-Disciplinary Alliance for Children. Women’s Aid consults our members by means of a telephone consultation on every Ofsted Inspection of CAFCASS and provides evidence to Ofsted as part of their reviews.

**Key Issues**

2.1 Neglect—The impact of neglect and the long term consequences of a delay in intervention where there is evidence of neglect

2.1.1 Women’s Aid believes that no discussion of child protection in England can be conducted without looking at the disproportionate impact of neglect on children and young people.

2.1.2 As well as the statistics above of children subject to a child protection plan who have been neglected, the NSPCC estimate that 9% of young adults had been severely neglected by parents or guardians during childhood and that one in ten children have experienced severe neglect. Action for Children, after wide consultation with a range of professionals from different sectors working with children has also estimated that one in ten children in the UK experience some form of neglect. Their research found that the majority of professional have come into contact with children who have experienced neglect—Primary school staff are most likely to believe they have had contact with a neglected child (81%), followed by health professionals (69%) and pre-school/nursery staff (67%).

Ofsted has also found neglect to be a major contributory factor to severe harm or death of children. In their 2010 report, 5 out of 13 deaths which were deemed to be accidental had neglect as a major contributory factor and they also found that out of nine serious case reviews where the deaths of the children involved were deemed to be from natural causes, neglect may have been a factor. Furthermore, out of 109 cases which involved severe harm, neglect was a major factor in the majority of them.

2.1.3 It has been suggested by a range of commentators that there are four key types of neglect:

1. **Physical and nutritional neglect** including abandonment/expulsion from home, inadequate feeding/nutrition, inadequate clothing or physical care.
2. **Medical neglect** including denial of/delay in/failure to provide or permit adequate health care or treatment.
3. **Inadequate supervision** including lack of appropriate supervision, conspicuous inattention to avoidable dangers, exposure to hazards and risk, leaving with inappropriate caregivers.
4. **Emotional neglect** including inadequate nurturing or affection, exposure to chronic abuse or violence, delay in or refusal of psychological care and treatment, over protective restrictions that foster immaturity or emotional over-dependence.

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290 Channel 4 despatches child homicide study (July 2009).
293 The publication of 29 Child Homicides raised the profile of child contact and the risks that unsafe child contact can pose to both the child and the non-abusing parent (usually the mother).
294 Letter dated 16.7.2002 to Women’s Aid Federation of England from Rosie Winterton, Parliamentary Secretary, Lord Chancellor’s Department.
295 Radford et al. (2011), op ci , based on a survey of 1.761 young adults aged 18–24 years.
296 Ibid. based on a survey on 2,275 children aged between 11 and 17.
298 Ibid. page 21.
Research has argued that despite an acknowledgement that the longer term impact of neglect on children may be worse than for physical abuse, somehow the nettle has not been grasped. Assessment and protection plans have been less effective than for physical abuse.  

2.1.3 Although neglect accounts for the largest proportion of children subject to child protection plans, in families where long-term neglect has taken place social care often fails to take into account the history and has adopted what Brandon et al have described as the “start again syndrome”, meaning that many children and young people are left living in appalling situations of neglect and abuse. This is borne out by the figures of young people who figure in serious case reviews due to neglect as discussed above. Neglect can be a difficult issue to identify and may often involve a value judgement on the family involved. Professionals may be reluctant to be seen as “pathologising” families living in poverty and as Ventress has stated “neglect among families with higher levels of socio-economic resources, while just as damaging as neglect among poorer families, can be more difficult to identify.”

Women’s Aid recommends that:

1. Cases where neglect is a factor need to be given the same weight as physical abuse to ensure that, as Lord Laming has said, “where children are supported at home, the child protection plan must clearly identify the objectives to be achieved, with timescales, that signal either the withdrawal of support to the family or, if the objectives are not achieved, indicate the point when further action must be taken. This is particularly important in cases of child neglect where often there is no single event that ‘triggers’ matters escalating to an application for a court order … Realistic timescales need to be applied for these cases to ensure that a child is not subjected to long-term neglect.”

2. All social care and all other professionals who come into contact with children receive comprehensive training on identifying neglect as a form of child maltreatment.

3. Families who do not meet the thresholds for intervention in child neglect cases should receive comprehensive support, including basic care and parenting to enable families to support their children.

4. Where domestic violence is identified as a factor in neglect cases, the mother and her children should both receive support and referral to specialist support services to address the domestic violence.

2.2 Older Young People—Older young people (especially those aged 15 to 19) and child protection

2.2.1 Teenage relationship abuse, a child protection issue in itself, consists of the same patterns of coercive and controlling behaviour as domestic abuse. These patterns might include some or all of the following: sexual abuse, physical abuse, financial abuse, emotional abuse and psychological abuse. However, there is a lack of recognition of the seriousness of teenage relationships because they are more likely to be short-lived. This does not mean that they can not be as abusive as adult relationships—in fact research has shown that teenagers experience as much abuse in their intimate relationships as adults, with several studies showing that up to 40% experience abuse. A study by the NSPCC and Bristol University questioned 1,353 young people (aged between 13 and 17 years old) on violence in their intimate relationships found that 33% of girls and 16% of boys reported some form of sexual abuse; 25% of girls (the same proportion as adult women) and 18% of boys reported some form of physical relationship abuse and around 75% of girls and 50% of boys reported some form of emotional relationship abuse.

By the same token, older young people are also at risk within their family homes and many may have lived with child abuse and neglect for their entire lives. Older young people are likely to display a wide range of effects of abuse and neglect. Brandon et al found that long-term neglect and abuse had led to self-harm and suicide attempts in older young people the subject of serious case reviews. The NSPCC’s 2011 report into...
child maltreatment found that over a quarter (25.3%) of young adults aged 18–24 had experienced child abuse.\(^\text{308}\)

2.2.2 Despite the levels of abuse experienced by older young people, both in the home and in their own relationships, they experience poor responses from social care professionals and from professionals from other sectors vis-à-vis child protection. Cleaver and Walker’s 2004 study found that both the volume of referrals and also the numbers of child protection referrals decreased with age.\(^\text{309}\) The study also found that the age of the young person was very much associated with the percentage of cases which progressed to initial assessment where the referrals were much lower for young people aged over 15.

Recent research has also found that both in the UK (although there is little written on this) and Canada that young people are themselves very unlikely to make disclosures of abuse.\(^\text{310}\) Women’s Aid’s own research supports this.\(^\text{311}\) The Action for Children report also found that young people are concerned that they will not be believed or that their families will have intervention from social care. This research supports findings from a range of other sources which highlights the difficulties young people experience in trusting professionals to make decisions about their welfare.\(^\text{312}\)

Women’s Aid has also found that young people are afraid to report abuse to teachers, police or social care because of breaches of perceived trust by professionals or the “gossip effect”. A number of posts on our specialist messageboard for young people are outlined below (we have not included any names for confidentiality reasons).

I couldn’t go to the GP! It’s my mums as well and she’s got friends that work there, if she knew I’d told someone she was friends with I don’t think life would be worth living!

I want to get onto the court case so I can fight for my little brother but no one will help me. His cafca appointed guardian isn’t acting appropriately either and has lied in loads of reports based on interviews and things but I cant even complain about her. I just dont know what to do any more! everyone I ask or turn to says I cant do anything. I can’t sit here and let my brother go back on contact, I just want to help my mum fight after everything she has done and how strong she has been with everything!

Two months ago today I had one of the worst experiences of my life. I’m only 16 and went through a really bad time with my old boyfriend. I went to see him and then we were in his room and I don’t even know what happened but we started to argue he accused me of cheating on him with one of my family members which is impossible and then when I said I didn’t feel safe and wanted to leave he got very angry, slamming the door shut pining me down on the bed and punching me several times. I was bleeding etc and he carried on, no body was in and I was so so scared, after a while I managed to kick him off and ran out however he stopped me and pulled me back ripping my clothes and then spraying foam hair spray all over me in my eyes and mouth ... he carried on by trying to drown me and knocking me unconscious. When I came round I was dragged down stairs and he pushed me into the rain. I was so scared and was screaming for help, he had broken my phone and thrown my bag and all possessions in a lake behind his house. Eventually someone came and they called the police. Unfortunately the police decided because of our ages (15 and 17) they couldn’t take it any further. However I believed it would all stop I would never see him again but it all continued ... he had explicit photos that he sent to class mates, people I didnt even know and family members it ruined me.

He turned up at my house he ruined my prom and left me scared to go on holiday after over three weeks. It was unbearable. The police again unfortunately couldn’t help me and with all the damages to my things I ended up over £650 out of pocket.

Thank you, unfortunately I cannot change my phone number due to a fixed contract. I have text after text logged but even when I have tried to reinvoice the police they do not want to know. I have lost all faith in them and see no point with trying anymore. It’s my first day of college Monday and I’m petrified, I have to walk past his road and I’m scared I’ll see him. I really can’t sleep and don’t know what to do.

We have also found, as outlined in our previous submission to the Committee, that young people often do not recognise abuse, especially if it is within their own relationships or they have grown up with abuse and have not received any specialist support. Women’s Aid moderated the messageboard on two occasions during the previous two Home Office Teenage Relationship Abuse campaigns and found that young people want

\(^{308}\) Radford \textit{et al} (2011), \textit{op.cit.}


\(^{311}\) See for example Barron, J, (2007), \textit{Kidspeak: Giving Children and Young People a Voice on Domestic Violence}, Bristol: Women’s Aid.

information about abuse and how to make their own lives safer but they also do not recognise when they are in abusive relationships.

Women’s Aid recommends that:

5. Children and Young People’s Social Services provide specialist support for young people experiencing abuse in their own relationships or at home to ensure that they recover from the domestic violence and grow up to achieve their life potential and have healthy adult relationships.

6. All children and young people receive comprehensive education on healthy relationships and safety planning and that this is mandatory within the Sex and Relationship Education (SRE) and Personal, Social, Health and Economic Education (PSHE Education) curricula.

7. Women’s Aid recommends that police, social care and other statutory agencies recognise teenage relationship abuse as posing the same risks to the safety of young people as adult domestic violence.

2.3 Thresholds—Thresholds for intervention, for taking children into care and for adoption

2.3.1 Removing children from their families is a delicate balancing act which should not depend on the resources available to the relevant local authority or the number of referrals that the local authority has received. At the end of March 2011, there were 65,520 looked after children which represents an increase of 2% on 2010 and 9% since 2007.313

Despite the commitment by the Government reviews, including Munro and Allen, early intervention is still not the consistent option for many local authorities. The reviews have identified that it is far better for children’s welfare to intervene early to ensure that they are not at risk of harm and that it is not necessarily in their interest to be removed from the family.314 This is supported by Lord Laming’s earlier work, where he has posited that “early intervention is vital—not only in ensuring that fewer and fewer children grow up in abusive or neglectful homes, but also to help as many children as possible reach their full potential”.315

There has been much discussion of thresholds over the social work literature of the past decade and many commentators have acknowledged that thresholds are unhelpful as they are often apparently set dependent on budgetary constraints. A recent study of 170 frontline social workers in Community Care found that 82% believe that they are under pressure to reclassify child protection cases as less serious with budget cuts, increases in referrals and a lack of social workers given as the main reasons.316 The same survey found that teenagers were suffering the most from reclassifications, with many social workers claiming teenagers were falling off the child protection agenda. One wrote: “Child protection plans seem to be for the younger children.” Another social worker said the most pressure to return or keep children with birth families came when children were over the age of 15: “I’ve often heard the argument ‘well they’ve managed to survive this long’.”317

This is a situation has been highlighted in earlier reviews including in Brandon et al who had said back in 2008, The reviews identified not only confusion and misunderstanding of thresholds, but also a preoccupation among agencies with eligibility criteria for services rather than a primary concern about the child or children with whom they were working.318

2.3.2 At the same time, Women’s Aid has evidence that women in domestic violence services have had their children removed because of a perceived failure to protect their children from domestic violence and that this situation is increasing. Women’s Aid is concerned that it is the perpetrator who poses the risk and where the perpetrator is not with the mother (who is also a victim) it is more effective to support the mother in order to protect the child and that in many of these cases it is not in the interest to the child, the mother or the public purse to remove these children and young people. It is also vital that action is taken to manage the risk posed by the domestic violence perpetrator and interventions made to change the domestic violence behaviours of the perpetrator (usually the father or step father but this may also include other family members in cases of forced marriage and so called ‘honour’ based violence).

“We have seen a massive increase in the numbers of women who are being told, ‘go to a refuge now or else you’ll lose them kids’ [sic]” (Women’s Aid Member, 2011)
“We’re seeing more and more women losing their children because of the domestic violence. They are not living chaotic lives or have drugs and alcohol problem but because of a return to the ‘failure to protect’.” (Women’s Aid Member 2011)

The Children Act 1989 legislates for a duty on local authorities to make reasonable efforts to rehabilitate the child concerned in proceedings with his or her family unless it is not in the best interests of the child. The majority of mothers who live with domestic violence are able to parent effectively, especially with additional support; support which is decreasing due to budgetary cuts across local authorities matched by an increase in referrals at the same time. Taking children into care should not be seen as a measure of last or of first resort but should be considered amongst the spectrum of specialist support available to families.

Women’s Aid recommends that:

8. Early intervention is given top priority amongst statutory child protection bodies and that a focus on thresholds rather than individual risk should be avoided.
9. All professionals working in social care receive appropriate training on the dynamics of domestic violence rather than the piecemeal training received currently.
10. Budget cuts should not be used to allow thresholds to increase nor should the cuts mean that children are left in neglectful or abusive homes for long periods of time.
11. Older young people receive the same focus as younger people and are seen as child protection concerns in the same way by police and social care.

April 2012

Written evidence submitted by: Jan Loxley-Blount T Cert, Dipl Child Development. on behalf of: Parents Protecting Children UK (Parents, Professionals & Politicians Protecting Children with Illness and/or Disability)

1. THE IMPACT OF NEGLECT AND THE LONG TERM CONSEQUENCES OF A DELAY IN INTERVENTION WHERE THERE IS EVIDENCE OF NEGLECT

A. When considering the risks of delay, I would remind the Committee of the dangers of over hasty action, especially in cases where suggestions of abuse are challenged on grounds of disability and/or chronic illness.

B. There is a letter circulated on 11/12/11 signed by:

— Jan Loxley Blount, T Cert, Diploma in Child Development, Parents Protecting Children UK.
— William Bache DipLG, Senior Director William Bache & Co., Solicitor with Higher Rights (Criminal), Member of The Children Panel. Acted for Angela Cannings & in other high profile cases of false accusation on disputed medical grounds.
— Beverley A Lawrence Beech, Hon Chair, The Association for Improvements in the Maternity Services & Jean Robinson also of AIMS.
— Jane Colby, Executive Director, The Young ME Sufferers Trust.
— Dr Peter Dale, Child Protection Researcher, Author and Expert Witness.
— Margaret Gardener, False Allegations Support Organisation.
— Trevor Jones, Richard Roper & Alison Stevens, Parents Against Injustice Network.
— Countess of Mar, Chairman, Forward-ME.
— Dr Dinah Murray, Tutor in Autism at Birmingham University. Founder Autreach IT. Author & journal contributor in the field of Autism.
— Mary-Jane Willows, CEO of the Association of Young People with ME.
— Dr Lynne Wrennall, Coordinator—Public Health Research Group., Liverpool John Moores University. Extensive published research into expert witnesses & child protection errors.

Over hasty adoption could lead to children of disabled or sick parents being lost to them forever.

I am writing to you on behalf of Parents Protecting Children UK and a number of other voluntary groups, academics & others, who find themselves supporting families who are wrongfully caught up in the Child Protection and Family Court system.

We appreciate that for those children without a viable family of origin, adoption would be preferable to languishing in care and that speedy placements could be in the child’s best interest. Safeguards would need to

ensure that proper checks and procedures are followed and that the child and the new family are completely happy with the procedures and the placement.

However in a straightforward case, six months in the Family Courts would be an extremely short period in which to ensure that everything is done thoroughly and considered properly. In complex cases it is simply unrealistic.

Last month a mother attended court to make an application for increased and improved contact arrangements with her children, whilst still fighting to prove that a report claiming her to be an unfit parent was erroneous. Anxious to be seen to be acting quickly in the ‘child’s best interests’, Social Services had “piggy backed” an order to free the younger child for adoption onto the contact application. The freeing order was granted and the contact application unheard. The child is now to be placed permanently with a new family, notwithstanding that the mother and older sibling are desperate for the family to be reunited and that there were medical reasons with which to challenge the damning assessment.

We can see this kind of injustice being repeated time and time again if family court procedures are to be drastically foreshortened as currently proposed.

If adoption targets and procedures are to be speeded up then it is absolutely vital that the issue of false and misleading accusations of child abuse is dealt with BEFORE any changes are made.

The number of false and misleading allegations of child abuse is extremely worrying. A significant number of these are in families where a child and/or a parent has Asperger’s Syndrome or another Autism Spectrum disorder. Other reasons include historic mental health issues, ME/CFS, metabolic disorders, learning disabilities etc etc. It is frighteningly possible that these families could lose their children to adoption, before they have time to prove their innocence.

The only way to bring the false accusation issue to a head is through a Parliamentary Select Committee Investigation. This was proposed in the Lords by Earl Howe (now a junior Minister in the Dept of Health) as long ago as 2001.

“I hope that the Government will take these issues in hand and examine them seriously. It is a subject which a Select Committee, either in this House or in another place, could examine to advantage. Having made a personal study of these matters, I believe them to be of deep significance for the well-being of countless children and families up and down the country.”

Earl Howe. House of Lords Hansard 17/10/2001

A trawl through Hansard will reveal similar concerns and requests by amongst others Lord Tim Clement Jones, the Countess of Mar, John Hemming MP and by Tim Loughton MP the Minister now concerned with adoption.

There is an e-petition quoting back Earl Howe’s 2001 request.

C. The full text of the e-petition is below.

Call for Select Committee to investigate Misleading Allegations of Child Abuse & meanwhile suspension of change to Adoption & Family Court proceedings.
http://epetitions.direct.gov.uk/petitions/22259

Responsible department: Department for Education

We call for a Parliamentary Select Committee to be established to investigate and report on the issue of False and Misleading Allegations of Child Abuse. We demand a suspension of any plans to limit Family Court time, or speed up Adoption procedures, until the Select Committee on False and Misleading Allegations of Child Abuse has completed its investigations and its recommendations have been fully implemented. The current government proposals on Adoption targets & Family Court procedures are potentially dangerous as children could be adopted before loving parents have the time to prove their innocence. There are particularly time consuming problems and processes in families where parent, child or sibling has a disability, including Autism Spectrum disorders &/or chronic medical or mental health difficulties.

— The e-petition was deliberately set to run for a short time—three months only—it closes on the 10 February.
— Signatures to date on 22/1/12 total 137 and are known to include academics and organisational representatives as well as Parent Carers and others directly affected.

2. OLDER YOUNG PEOPLE (ESPECIALLY THOSE AGED 15 TO 19) AND CHILD PROTECTION

Evidence from recent or current cases in the press and/or which have come to the direct attention of Parents Protecting Children UK and related organisations give cause for concern.

A. Children of an age and ability where they could be considered Gillick competent don’t seem to be properly consulted about their placements or included in decision making processes. It appears that when social workers have decided on a “plan of action” for a young person, it is irrelevant to them that this may not be what the young person actually wants!
— In a current case, complex and expensive arrangements are being made to rehouse one parent to provide space for their teenager—withstanding that the teenager wants to go home to their own room with their other parent with whom they grew up. Social services objection to the original parent is based on a contested report about a supposed personality disorder (almost certainly an Autism Spectrum disorder which would not preclude parenting). The Local Authority will not allow reassessment of the young person or original parent to consider alternative diagnoses.

B. There may be evidence of sexual grooming in care. I heard this directly from a parent of a Northern Irish teenager. I later heard a BBC Radio 4 report which appeared to confirm the parent’s fears. http://www.bbc.co.uk/news/uk-northern-ireland-15625438 7/11/11

C. There is evidence of Autism Spectrum teenagers being taken into care, supposedly to encourage independence. Faced with an unfamiliar environment the teenager’s behaviour can become hard to handle and medication given which may not be suitable.
— I know of a historic case where the young person regressed on medication and became a highly dependant adult, now costing the local authority a great deal of money.
— The press recently reported the death of a young man in similar circumstances. Ham & High http://tiny.cc/x0550 9/1/12

D. There are problems concerning vulnerable teenagers and young adults with learning disabilities, on the Autistic Spectrum, or those who are non-verbal, whose home situations can be misunderstood. Some such young people are sometimes held in care against their will.
— Amongst these is the much reported case of Steven Neary. Daily Mail http://tiny.cc/n3lvq 10/6/11
— There is a Welsh case, currently before the Ombudsman, in which a vulnerable young person was taken from day care and incarcerated for 5 months by social services. Indications are that the Local Authority, Police, medical services etc are ready to apologise. The family are slowly recovering from their ordeal.

E. There are further concerns about vulnerable older teenagers/young adults and the Court of Protection highlighted in an article from the Daily Mail http://tiny.cc/4vivj 22/5/11

3. THRESHOLDS FOR INTERVENTION, FOR TAKING CHILDREN INTO CARE AND FOR ADOPTION

3.1 Autism etc

A. The Equalities Act 2010 and the Autism Act 2009 are being disregarded.

B. Cases come to the attention of Parents Protecting Children UK, Parents Against Injustice Network, False Allegations Support Network and other organisations supporting Parent Carers in families with Disability or Chronic Illness, in which thresholds for taking children into care or offering them for adoption are only reached because of a misunderstanding or misrepresentation of Disability or Illness. This is particularly true in the case of parental Autism or Asperger’s syndrome

C. Some parents, particularly those with Autism Spectrum disorders, find meetings with social workers, solicitors etc extremely stressful and need support to enable them present their case. Permission is frequently refused for a lay advocate to accompany a parent when attending such meetings.

D. There is a French Film Le Mur (The Wall—subtitled) which explores issues surrounding Autism and Psychoanalysis. It may be helpful for the Committee to spend 50 minutes watching this. The UK situation is more subtle, but the same underlying philosophy is present in the training of UK Social Workers and others. Psychoanalytic Theory is mis-used in the UK to suggest that mothers & fathers with Autism & Asperger’s Syndrome may have Borderline Personality Disorders. It should be remembered that at the time Psychoanalytic theory was being developed there was little or no understanding or recognition of Autism or Asperger’s Syndrome. It seems that UK parents with the disability of Autism or Asperger’s Syndrome are being denied the right to family life. This may actually be worse than the horrendous situation in France.
— Huffington Post http://tiny.cc/2qi7e 5/12/11
— Facebook http://tiny.cc/wr1w7
— YouTube http://tiny.cc/qw2vo

3.2 Babies

In 2002 in the case of P., C. & S v UK in the European Court of Human Rights http://tiny.cc/6e0j4 the UK was held to account for moving to adopt a baby without a trial of parenting. More information can be found at http://tiny.cc/bse7q It seems that this judgement and the lessons learned are being discarded and forgotten in the current scramble for more and faster adoptions. There will inevitably be more and more similar UK cases reaching the European Court but by then it will be too late as adoption is irrevocable and families will be unjustly broken up forever.
Parents Protecting Children UK, Parents Against Injustice Network, False Allegations Support Network AND many academics, lawyers, related organisations etc, some of whom are included in the list at 1B above, believe that an urgent Parliamentary investigation of False, Mistaken & Misleading Allegations of Child Abuse MUST be undertaken BEFORE any moves towards faster adoption are implemented.

April 2012

Written evidence submitted by Dianne Harper and Paul Staniforth

CHESHIRE EAST SOCIAL SERVICES

BACKGROUND

1. We became involved with social services when our niece was suddenly widowed leaving her with the care of eight children ranging from one year to 15 with the youngest having special needs. My niece Joanne was unable to cope with the demands of the children and still grieving for her husband social services became involved on the basis of emotional and physical neglect the children being unkempt, clothes dirty and inappropriate clothing for the weather.

2. We totally appreciate that social services should be involved however rather than supporting her through this process; my niece was left to flounder without the support to ensure the children remained with their mother. They provided action plans with guidance for her to address failings in her care which she was unable to sustain, but without any thought that she was still grieving for her husband who had died only weeks earlier. She was provided no practical support to help with the daily care for children but rather pressured to address failings and coerced into placing children voluntarily into care.

3. There was no physical or sexual abuse involved but their was some neglect in terms of caring for the children and ensuring they were clean, attended medical appointments and dressed appropriately. My experience of the social workers was that they were initially supportive but one by one took each child into the care system despite the children wanting to remain with their mother. The impact emotionally of losing their father then to have the mother taken away from them must have some long term impact on their social and emotional well being. The children were distressed, fraught and made it clear they did not wish to go into care wishing to remain with their mother. The family unit was split as one by one each child was taken into care with different families so not only were they removed from their mother but they lost the day to day contact with their siblings.

4. Social services failed to inform their mother of meetings and appointments which was they recorded that she failed to attend. They coerced her into placing children into care voluntarily with the threat of losing them all. They did not consult her in relation to weekly contact meetings and made the arrangements to suit themselves which were not always convenient to Joanne their mother. They consistently applied ongoing pressure without offering any practical support to ensure the family remained together.

OUR EXPERIENCE OF SOCIAL SERVICES

5). Myself and my husband took one of the children into our care Adalia. She resided with us from June 2009 until September 2009. At the same time we were going through formal assessment as family and friend carers.

6. One morning we awoke Adalia to discover bruises to her face. These were not present the day before and she had been sleeping with our 11 year old daughter all evening. We asked Adalia how she received these and she stated that these were inflicted at nursery and then named the person. We asked the nursery to account for her injuries and they refused any liability. This was reported to social services who then proceeded to investigate the incident with ourselves and the nursery resulting in hospital assessment and police investigation. Adalia was removed from our care by Cheshire East and placed with another foster carer. Adalia was distraught at being removed and they promised we could retain contact with her and she would be returned post the investigation. That was the last we saw of Adalia. We were left floundering with no support, no contact with social services and no communications re progress of the investigation or care of Adalia. We continually requested access to the children and received no response and no arrangements were made to ensure Adalia and the other children retained the bond with us. We were confident she would come back to us. (The police finished their investigation and it was inconclusive and despite us requesting her to be returned to our care in the family unit they refused). At no time were we implicated re her injuries although they did accuse our son who was five at the time despite us stating that our son had no window of opportunity and witness statements from parents at the nursery relating to the boy who injured her had inflicted similar injuries on another child).

7. We continually requested access to visit the children had we had a strong bond with them and Adalia herself and received no response and no access was arranged.

8. We then learned from another relative that they were placing the children for adoption. We were furious, that none our family had been consulted re care and ourselves as were willing to provide a home for the children with us. We discovered the adoption hearing was at court and wrote to the judge who made us parties to the hearing. Social Services objected to this and objected to us as party to the hearing. We started to fight the system to have Adalia returned it was however, very time-consuming, stressful and costly. The judge
ordered Social Services to continue our assessment and to make contact arrangements. They ignored this request and only on yet again being instructed did they abide by his judgement. At this point we had not seen the children for nine months and the bonds we had made and progress we had made were diminished. We continued to go to court and the judge was clear that if the only issue preventing us having Adalia returned was an inconclusive investigation then we should be considered. We continued to go to court but we constantly received assessments and reports implicating our son in Adalia’s injuries. This was totally unacceptable and not based on fact or evidence but their own conclusions. This was totally inappropriate, “every child matters” including our own. We therefore backed out of the proceedings but with much regret and much heartache that we had failed our nephews and nieces.

9. We felt we were fighting the system with no support from anyone and despite us being educated people with backgrounds in central government found that Social Services in Cheshire were a law to themselves blatantly not following their own policies and procedures as set down in written policy and fabricating the truth. Therefore in terms of people less educated than us such as my niece and others they would have absolutely no understanding of what policy applies procedures that should be followed and therefore these families and their children are being failed by the system.

10. Based on our experience we would make the following recommendations to the select committee:

10.1 The impact of neglect and the long term consequences of a delay in intervention where there is evidence of neglect

— There is a national framework outlining the various levels of neglect and the actions and support that should be given to the families and their children so that there is a clear plan of action for each level. Some levels of abuse are much more serious than others and the framework needs to account for this.

— That as part of this framework the committee looks at providing more practical support to keep families together. My nieces children were removed and placed into care when with daily practical support helping to bathe children, help her with washing and helping them get ready for school and learning her the basics of good parenting the family unit could have remained together, This could be provided on a sliding scale of support where there is no wider family to offer this support. This would be less costly, have less of an emotional impact on children being removed into care and would provide an opportunity to prevent ongoing neglect. The support workers I met went into the home asked lots of questions, provided advice on action plans but no practical help was offered.

— That levels of neglect are clearly outlined, communicated and courses of action clarified. Since high profile cases, many departments are extremely cautious and are acting too heavy handed to remove children who with more support could remain with the family.

— Evidence of neglect should not be based on hearsay but should be fully investigated with supporting authorities such as schools, medical experts and action plans developed accordingly. Too often it is based on a report by a local neighbour without any substantiated from other areas.

— Where cases of neglect are inconclusive, there should be clear guidelines on actions to take weighing up ongoing risks and if these risks can be mitigated returning the child in their care with appropriate ongoing supervision/support.

— That in all cases the emotional impact of removing children from parents and moving them to another family is fully impacted. The long term damage of placing children into care when with more support they could remain in the family should be considered. My nephews and nieces will be emotionally impacted by the action taken and this does not appear to be considered.

— Adoption is the last resort. My niece did not want her children adopted but found it difficult to fight this and has thus ceased all contact with her siblings. This will be damaging to the children, the family unit is broken and even though we were wiling to place some of the children with us to a view to adopting we were not informed, considered.

10.2 Older young people (especially those aged 15 to 19) and child protection

— That older children’s views are considered throughout proceedings. Children of 15 to 19 have a clear understanding of where they wish to live and this should be given paramount importance unless of course they are at ongoing risk of severe abuse.

— Wherever possible where these are taken into care that they be placed within the extended family and relations with family members and parents encouraged with appropriate supervision.

— Where children are over the legal age to leave home, that support is given for them to live in the local area on their own ie in suitable housing or supported lodgings. Training given to them in terms of caring for themselves to encourage independence.

10.3 Thresholds for intervention, for taking children into care and for adoption

— Clear framework of intervention be developed outlining differing levels of neglect/abuse and clear guidelines on interventions for Social Services. The underpinning framework at the heart of this being to keep family units together wherever possible and to provide practical support for families.
— That an independent support network for parents to be established to provide independent advice for parents who find their children placed into care and with a clear route for complaints. Providing legal, financial, policy advice.

— That parents be given support workers who act for the parents alongside social services support workers whose main aim is the children and help them in terms of dealings with social services (independent from the social services department). This could be a volunteer group or something implemented by central government but with total independence from social services.

— That cases are in open court—too often cases are heard in private and social services word is paramount. Open courts would protect those families where children should not be removed and enforced care and adoption proceedings made.

— Adoption should be the last resort where there is no chance of placing children in long term care or them returning to their families although parents should have a say in whether they wish this to happen. Adoption targets should be removed as too often these encourage social services to place children for adoption in order to increase their budget and thus the children’s welfare is secondary. Latest statistics shows areas in the UK where adoption is prevalent.

— Even where children are adopted they should be encouraged to maintain some contact with the birth family. It’s important for children to understand their background, roots and to know they have a wider family network.

— The adoption process should be simplified. Children are being failed by the system to have secure homes because the process is complicated, time consuming. The process could be reduced and simplified.

— Financial help should be available for family members who wish to provide a home and cannot fight the system without legal intervention. It is very costly and even though family members may wish to provide a home, they then have to take legal action to pursue this in some cases without any support.

11. Lastly, I would like to offer support to this review if I am able. If you plan to set up any network or groups to review the social service policies I would like to offer as a volunteer to be involved.

12. I am sure that social services do a fantastic job in the main but there are clearly areas where the process needs to be reviewed and I encourage this review. At the heart of any of this policy must be the children affected and I think in some areas social services have lost sight of this.

April 2012

Written evidence submitted by Alastair Patterson

INTRODUCTION

I am a retired university lecturer in mathematics and would describe myself as a socio-forensic advocate. I take the term from the CAFCASS description of function, I work in the same discipline; from Independent Complaints Advocacy in mental health, where I also work, and from section 26A(1) of the Children Act 1989. I advice, assist and advocate, through the statutory complaints processes and at all levels of the courts, in disputes on the state’s support for, and intervention in, family life. I take referrals from the third sector in private and public family law, mental health, criminal law (probation, appropriate friend and custody visitation), benefits and debt enforcement.

EXECUTIVE SUMMARY

— There is an unpublished and unacknowledged policy to evade local authority statutory duties to provide social services to the families of children in need and in particular to vulnerable and disabled parents for eradicating child poverty as the Children’s Act 1989 intended.

— More generally, through section 17(1), and under the generic heading of safeguarding and promoting the welfare of children the act intended for the state to work in partnership with the family in delivery of all of the state’s services to the child. Coupled with section 2 parental responsibility, which the act also introduced, this gives parents control over all of the state’s services to their children.

— Parental control over public services to children appears to have been intolerable to officials in local and national government. They have mounted a 20 year deception to evade Parliament’s intentions and the provision of local authority services to children in need.

— The deception has been hidden in the child protection system and the confidentiality of family proceedings. Operation of the local child safeguarding boards has been subverted to perpetrate the deception. This has rendered the boards ineffective and is the cause of the child protection problems being investigated by the committee.

— Emotional harm has been invented to evade provision of local authority social services to vulnerable and disabled parents of children in need and to wrongly remove children from their families instead.
— Social workers from the local authorities and Children and Family Court Advisory and Supervisory Service (CAFCASS) invent nonexistent child protection powers using them to delight in abusing vulnerable and disabled parents with false claims of bogus forms of harm instead of providing these services.

— The academic and clinical discipline of child development has been suppressed and there are no measurable outcomes for public services to children. The emotive, but undefined, welfare of the child is used to avoid any accountability for public services to children. The devastating impact on child poverty is described in the reports of Frank Field and Graham Allen. The adoption crisis is a direct consequence of the deception.

— Herein is described:
  (a) the misuse of initial and core assessments to perpetrate the deception;
  (b) the consequent failure of the child protection system and the poor progress in eradicating child poverty;
  (c) the mechanism used to invent emotional harm so to evade the provision of services to children in need and its use by social workers to abuse vulnerable and disabled parents under the guise of child protection;
  (d) the correct child protection process;
  (e) the correct use of initial and core assessments, in conjunction with the section 1(3)(a-f) welfare checklist, for determining local authority services to children in need;
  (f) the correct child safeguarding risk assessment by application of section 1(3)(a-f);
  (g) the means by which the deception is being perpetrated in the local authorities, Children and Family Court Advisory and Supervisory Service (CAFCASS) and in family proceedings;
  (h) the application of section 1(3)(a-f) to all of the state’s services to the family; and
  (i) the legal device that is used by the local authorities to perpetrate the deception.

— It is concluded that:
  (a) Part I of the CA1989 should be seen as attached to all other statute giving parental control over all the state’s services to the child, through the welfare checklist, as implementation of the international rights instruments in the UK;
  (b) Parliament intended that the CA1989 that the parental right to state services for the child to fulfil their parental role is the correct expression of the child’s best interests; and
  (c) all the problems are easily solved by the Lord Chancellor exercising his powers under section 7(2) of the Children Act 1989 and making regulations setting out the application of the section 1(3)(a-f) welfare checklist.

**The deception to evade providing local authority social services to children in need**

1. The intentions of the Children Act 1989 are stated in the headnote, “to provide for local authority services to the families and others of children in need”. The provisions are set out in part III of the act and Part 1 Schedule 2 of the act. In particular section 17(1) of Part III defines the local authority statutory duty to safeguard and promote the welfare of children in need by the provision of services to their families. Section 17(10) defines children in need by the likely impairment of their health and development. The services have never been provided and there has been a 20 year deception perpetrated by officials in local and national government to evade making these provisions.

2. The deception to evade these services centres on misuse of the initial and core assessments devised by the Department of Health as the means of assessing the family’s circumstances for provision of the services. The assessments should be used as part of an adult social care assessment for adults with children. The child’s needs are treated as an extension of the adult’s needs in terms of parental incapacity within the family’s circumstances and services are provided to strengthen and supplement parental capacities. By definition, the impairment of parental capacity in meeting the child’s developmental needs is a form of disability and the intention is to support that incapacity.
3. It is the duty of the local authority to provide services to the parent that will enable the child’s needs to be met, it is not the parent’s duty to meet the child’s needs alone, "The notion of partnership between State and families is thus also established in this Part [III] of the Act".326 The parent’s duty is to ensure that the child’s needs are met by the services provided by the local authority, but as services are not provided parents, especially those with any disability, are persecuted for not meeting the child’s needs. Just as the child’s educational needs are met by the parent working with the education system, the parent would not be expected to home educate.

4. The initial and core assessments are assessments of the child’s circumstances for the provision of services to the family to supplement and strengthen parental capacity under Part III and Part 1 of Schedule 2 of the Children Act 1989.327 Child protection is a continuation of the assessment process, the assessment process is integrated into child protection process but it is not the child protection process.328

5. The deception has been to remove initial and core assessments from Part III, and along with it the duty to provide social services to families of children in need, and place them in child protection through the child safeguarding boards. Initial and core assessments are assessments of the child’s circumstances and not an assessment of the child, as such they are not only completely ineffective for child protection they actually obstruct the process as the child is never assessed. The sleight of hand to make initial and core assessment child protection and so evade the provision of services is at section 1.23 of Working Together.329 As seen, child protection is not part safeguarding and promoting welfare as claimed there.

The child protection failures

6. Because the core assessment has been called child protection, there is in fact no child protection process. The local authorities and CAFCASS are unable to provide the means by which to recognise and identify a child suffering harm, ie they do not know harm when they see it.330 The NSPCC have expressed concerns about the lack of child protection process.331 Just as in Baby P it is a matter of routine throughout the country that children are being abused under the noses of social workers assessing their circumstances and never the child. It is the cause of that universal theme in Child Protection Reviews of “loosing sight of the child”.332 They are never in sight, they are ignored throughout the whole process of assessing their circumstances for services that are never provided.

The failures in eradicating child poverty

7. Initial and core assessments are intended to determine services for improving the child’s health and development333 as the means of eradicating child poverty.334 The academic and clinical discipline of child development has been suppressed and the services have never been provided. The devastating consequence on child poverty described in the recent reports by Frank Field and Graham Allen based on their analysis of child development.

8. Emotional harm is the invented form of harm which actually means impairment of development. Impairment of development is inevitable if social care services (delivered on the health care model, see later) to promote development are not provided just as the impairment of health is inevitable if health care services are not provided.

9. Emotional harm nicely encapsulates the deception: rather than provide social care services that strengthen and supplement the parental capacity in meeting the child’s needs and improving the child’s development the parent is falsely persecuted for not meeting the child’s needs. Parents are told they cannot meet the child’s emotional needs and will cause him emotional harm just as not providing schools would mean that the parent was unable to meet the child’s educational needs, presumably causing him educational harm.

Abuse of disabled and vulnerable parents under the guise of phony child protection

10. The process intended to alleviate child poverty is being used to persecute the poor for exactly same the reasons they need to be supported in alleviating child poverty. In fact, under the guise of child protection with phony claims of emotional harm and citing non existent legal powers, social workers delight in the opportunity
to abuse the vulnerable and disabled that they are meant to be supporting. The only powers the local authority have to prevent child ill treatment and neglect are the provision of services under Part III of the Act, which they do not provide, and instead cite non existent powers to abuse vulnerable and disabled parents under the guise of child protection.

11. Both local authority social workers and CAFCASS officers use ridiculous and unworkable contact arrangements with children as the primary means of abusing the child’s parents. Under the guise of phony child safeguarding from the invented “emotional harm", the same social workers promote parental alienation in child as a means of securing the evidence they need to persecute parents (in private law by encouraging the hostile resident parent). The real fear of retribution being taken through the child in the event of any complaint renders the complaints processes impotent in protecting against this abuse.

The adoption failures

12. This is the cause of the adoption problems, the child is just an instrument of abuse and once that instrument has served its time and been taken away it is left to rot in the care system. The intervention threshold for the child is too high, too much damage is sometimes done before intervention but too low for a parent if left unsupported. If the parent was supported then the intervention threshold for the child could be lowered but for the parent, supported with social services, raised.

The correct child protection process

13. The child protection process, under section 47(1) of Part V, should be an investigation of the child, not the child’s circumstances to establish if the child has suffered harm. Processes for assessing the child to recognise a child suffering harm, such as those employed in health care, should be used but are not.

14. The possible outcomes of a section 47 investigation are: the child has not suffered harm; the child has suffered harm but it is not likely to reoccur or the child has suffered harm and it is likely to re-occur. There are no processes in child protection for assessing if a child is suffering harm because the initial and core assessments have been used in the deception to evade providing services. If a child has been found to suffer harm then the decision on whether the harm will reoccur is the child safeguarding risk assessment process. It has to be addressed in light of the support given through the provision of services to the family.

The correct assessment process for determining services for children in need

15. The process for determining local authority services for children in need is based on the section 1(3) welfare checklist. The initial assessment mirrors section 1(3)(a-c) of the welfare checklist in determining services for the families to improve the child’s health and development. It is an assessment of the child’s circumstances in terms of the section 1(3)(a) child’s wishes and feelings for those services in meeting the section 1(3)(b) child’s needs and the section 1(3)(c) likely effect on the child’s health and development of the change circumstances following the provision of services.

16. These services are referred to as universal services where social care is provision is modelled on health care provision. The process is described by the Law Commission as “akin to visiting a GP” and has recommended an adult version of the welfare checklist for determining adult social care provision. The professional function of a social worker is just that, to assess, advise and inform on services when supporting services users “to make informed choices about the services they receive”. No social worker has any training, knowledge, experience or competence in child development. No social worker is capable of informing and advising on child development, it is a completely valueless function.

337 ibid Children’s Commissioner’s Report, see also Practitioner-Client Relationships and the Prevention of Abuse (General Nursing and Midwifery Council 2002).
339 The Uttiing Report “Safeguarding Children Living away from Home” (Department of Health 1996).
342 Section 17(4A) Children Act 1989.
343 Ibid Working Together at 1.25.
The correct child safeguarding risk assessment process—core assessment

17. The section 1(3) welfare checklist merges harm from child protection in Part V, through impairment of health and development (section 31(9)), with the child’s needs and the provision of services to improve his health and development in Part III.

18. The section 1(3) welfare checklist connects the services provided under Part III and section 17(10)(b) “significant impairment of health and development” with “significant harm” found to be suffered under Part V at the section 31(2)(a) the public law threshold which is partly defined as significant impairment of health and development. However, in section 31(2)(b) the harm must be attributable to the care it would be expected a parent to give in partnership with the state. That is, the deficiency in care resulting from some parental incapacity. The role of the core assessment is to, as accurately as can be, identify that incapacity and strengthen and supplement it by the provision of services.

19. The core assessment mirrors the section 1(3)(a-f) of the welfare checklist in determining services for the family when the child is likely to suffer a significant impairment of health and development. These are referred to as specialist or targeted services. Section 1(3)(d-f) connects section 1(3)(e) harm the child has suffered or is likely to suffer at the public law thresholds to services provided to meet the section 1(3)(b) child’s needs. The core assessment is based on factual findings of harm suffered or likely to be suffered, where harm suffered through ill treatment may not necessarily impair development,346 at the threshold criteria before section 1(3)(c-f) can come into play. The welfare checklist is applied after findings of harm have been made, “the welfare stage”.357 It cannot not be applied as the means of finding harm suffered, as it used to determine services to address the parental incapacity which allowed that harm to occur in preventing it from re-occurring.

20. The correct risk assessment process following the core assessment is the likelihood of the section 1(3)(b) child’s needs being met following:

— findings of section 1(3)(e) harm suffered, the parental incapacity to give care for which that harm is attributable, and the harm the child is at risk of suffering from the parental incapacity; as,
— the section 1(3)(f) parental capability to meet the child’s needs with services provided to strengthen and supplement their parental capacities in partnership with the state.348

In the education needs analogy, if it is found that the child has not attended school then what is the likelihood of the child’s education needs being met by the parent ensuring school is attended or must a supervision order be made. In the Probation Service such a process is called offender management risk assessment, the risk of re-offending.349

How the deception is perpetrated in CAFCASS the local authorities and the family courts

22. It is when the local authority believes that there is a risk that the harm will be reoccur that they should apply to the court with the core assessment set against the section 1(3)(a-f) welfare checklist for judicial confirmation for a human rights interference.350 This is Lord Nichols cardinal principle of the act. A letter before proceedings should be issued by the local authority, three months before proceedings, explaining the reasons for the proposed court application.351 It should be in terms of the local authority’s risk assessment following the initial/core assessment of the which the family should have been already been informed.

23. The connection between initial and core assessments and the section 1(3)(a-f) welfare checklist is avoided throughout the ministerial guidance. The statutory guidance “Working Together to Safeguard Children” has been falsified in sections 1.20–1.36.

24. However, in those sections of Working Together it is still possible to discern the 1(3)(a-f) welfare checklist. The welfare checklist is the device by which all state services to the family are delivered in partnership with the family. The services are categorised as health care, social care and education which correspond to the child’s physical health needs (physical health care), emotional needs (mental health care and social care) and education needs in section 1(3)(b) and go under the generic heading of safeguarding and promoting the welfare of children from section 17(1) of the 1989 act. This intention is confirmed by sections 10 and 11 of the Children Act 2004 where the outcome of of safeguarding and promoting the welfare of children are the outcomes of the Every Child Matters Agenda the UK’s implementation of the UN Convention

346 ibid the Framework at 1.27, re B (Children) (FC) [2008] UKHL at 54.
347 ibid Re B.
348 Such a process is vaguely described in Working Together at 1.25–1.31 and well described in Re L (A Child) (Contact: Domestic Violence) [2001] Fam 260 http://www.westerncircuit.org.uk/Documents/Pupils/PA130310/PA130310%20Case%20of%20Re%20L%20-%20Fam%202060.pdf
350 re B (Children) (FC) [2008] UKHL at 57.
351 See for example House of Commons Justice Committee.
on the Rights of the Child\textsuperscript{153}. The purpose of the falsifications in Working Together are to suppress this connection from public understanding.

25. CAFCASS report in family proceedings either having been asked by the court under section 7(1) on the welfare of the child or as children’s guardians and they have a duty under section 12(1) of the Criminal Justice and Court Services Act 2000 to safeguard and promote the welfare of children in family proceedings. Regulations should have been made under section 7(2) of the CA1989 setting out the correct application of the welfare checklist for safeguarding and promoting the welfare of children in section 7 reporting but they have never been made.

26. CAFCASS have a statutory duty under section 16A CA1989 to risk assess if a child is likely to suffer \textit{that} harm. That is, the application of the welfare checklist as the child safeguarding risk assessment instrument. However, whilst section B3.1–3.3 of the CAFCASS Safeguarding Framework suggests an offender management type approach section E1.2\textsuperscript{354} confirms that the welfare checklist should be employed in risk assessment to meet the outcomes of the Every Child Matters Agenda but it is not described as such. Instead there are ridiculous risk factors within the child’s circumstances that are a combination of prejudice and common sense but completely ineffective and nothing to with \textit{that} harm.\textsuperscript{355}

\textbf{The legal device for perpetrating the deception}

27. The mechanism for perpetrating the deception is now apparent. The welfare checklist, and core assessments should be applied to significant impairment of health and development in section 17(10)(b) of Part III for the provision of local authority services. Instead they have been applied to impairment of health and development as significant harm in sections 31(2)/47(1) as child protection and so avoid the provision of social services to children in need by the local authorities and enabling bogus claims of emotional harm suffered.

\textbf{Conclusions and the Correct Understanding of the Child’s Best Interests}

28. Part I of the CA1989 is attached to all other statute governing the state’s decision making through application of the welfare checklist. The section 1(1) child’s welfare coupled with section 2 parental responsibility, is the parental right for the state’s services for his child which is the state’s paramount consideration as the UNCRC of the Child Article 3 primary or paramount child’s best interests and the Article 8(1) right to private and family life in respect to children. It is what the current Prime Minister describes as the family friendly test for all legislation.

29. The welfare of the child, as in section 1(2), is the child’s article 2 and article 3 rights as the 8(2) qualification on the parental 8(1) right and the determinative UNCRC Article 3 best interests.\textsuperscript{356} The parental right to the state’s services for the child should be adopted as the expression of the child’s best interests as explicitly recommended twice by the Unite Nations Committee on the Rights of the Child.

30. It was clearly Parliament’s explicit intention for the Children Act 1989 as described by the Lord Chancellor who introduced the legislation, Lord McKay of Clashfern:

\textit{“…parents should be seen and treated as having the primary responsibility for securing the children’s and the family’s welfare, and (that) the State should act only as a helpmate and on request and not seek to take over the parental role.”}\textsuperscript{357}

and the Department of Health who sponsored the original bill:

\textit{“The Act (Children Act 1989) rests on the belief that children are generally best looked after within the family with both parents playing a full part and without resort to legal proceedings. That belief is reflected in: the new concept of parental responsibility; … the local authorities duty to give support for children and their families; …”}\textsuperscript{358}

31. The current Lord Chancellor should exercise his powers under section 7(2) and make regulations setting out the application of the section 1(3) welfare checklist so as to enable it.

\textit{April 2012}

\textsuperscript{153} Working Together at 1.20, 5.3.

\textsuperscript{354} http://www.cafcass.gov.uk/pdf/Copy%20of%20Cafcass%20Safeguarding%20Framework%202010%20new%20links.pdf

Repeated complaints have been lodged with the CAFCASS, which they refuse to acknowledge.

\textsuperscript{355} The Department of Education refuses to respond to FOI requests on the matter.

\textsuperscript{356} UNHCR Guidelines on Determining the Best Interests of the Child UNHCR 2007

\textsuperscript{357} http://www.essex.ac.uk/armedcon/story_id/000821.pdf

\textsuperscript{358} As quoted in “An Introduction to the Work of the Family Court Welfare Service” (1997), Home Office Probation Training Unit, as reported in 3(1) CAFCASS CONTACT PRINCIPLES PRACTICE GUIDANCE AND PROCEDURES 16.08.04.

Written evidence submitted by Jude Murray, Grandparent

1. SUPPORT, ADVICE, INFORMATION

— Families, especially grandparents, are not given advice, support, or information when grandchildren are taken into care.

— Parents and close relatives are not informed of procedures, action to be taken (until they have been put in place without discussion), or how to deal with situations.

— Parents and close relatives are not informed of complaint procedures or where to go for support and advice.

— When complaints are sent in they are put on hold while the case in question is dealt with, so what is the point of complaining. Actions are taken and cannot be changed once the final court proceedings have been decided; the damage is done and the family has no rights of justice. This makes complaining a waste of time and effort and leaves the family feeling unimportant.

— Grandparents have no rights at all and I for one feel isolated from my grandchildren and helpless to take any action or have contact with them.

— I have tried many times to find out information and advice from different areas but I keep hitting my head against a brick wall. I have been passed from one to another without success.

— There is not enough access to information when involved with family in care.

2. CHILDREN’S WELFARE

— Social services keep saying that the children’s welfare is the main issue but how can taking children away from their parents and close family when they are in no danger not affect their minds’. How must they feel when they cannot see or talk to the people who love them and they love back when and where they want to. They must feel unloved and/or uncared for. This feeling will stay with them throughout their lives and will affect how they go through life and choices they make. It is none the wonder that many children have gone through the care system end up as alcoholics, drug addicts, or criminals. Their heads are messed up and they need an outlet to relieve their pain and suffering. I understand that there may be the odd time when they need to be fostered or adopted for their own safety and I am in full agreement with this, but if they are not in danger I do not feel that this is necessary.

— Children will never be loved or cared for as much as their biological parents and family. I agree in minority cases adults can be cruel and endanger their own children’s lives but unless this can be proven, and the children are not in any danger, then they should not be parted from their family life.

— It is very unfair that parents should lose the rights to keep their children when no evidence can prove that the children are any danger.

April 2012

Written evidence from Kathy Rowe and Joyce Plotnikoff (Director, Lexicon Limited)

1. INTRODUCTION

1.1 We have both been involved, for the last 20 years, in raising concerns about the provision of support to young witnesses called to give evidence in criminal courts. Kathy Rowe was formerly a Local Safeguarding Children Board Manager and following her retirement retains an active interest in safeguarding children. Her former role included the management of the Humberside Young Witness Service, a service which receives between 800–1,000 referrals a year. This service was identified as a model of good practice resulting in Kathy Rowe being asked to assist the Ministry of Justice in developing national guidance for the provision of young witness support in local areas. The Humberside Young Witness Service also won a European Award for the best social welfare project in Europe. Joyce Plotnikoff is an Independent Consultant and Researcher whose involvement in issues concerning young witnesses goes back to the development of the first young witness pack in 1992 and who has been responsible for conducting research in this area, including research for the Ministry of Justice.

1.2 However, services to young witnesses remain very patchy across the country and the needs of this group of children, the majority of whom are young teenagers, (although very young children do give evidence) are not being met. We remain concerned about their marginalisation for a number of reasons:

— Children and young people are seen by government as witnesses first, rather than children and young people, and therefore fall within the responsibility of the Ministry of Justice.

— They give evidence often in very serious criminal cases of sexual and physical abuse.

— Between 40% and 50% are also the victim of the crime.
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— Resources for children and young people within the Criminal Justice System are disproportionately targeted at those children and young people who commit offences with very little resource allocated to children and young people when they act as good citizens and perform a valuable public protection role by giving evidence, often against very serious offenders. We are concerned at the message this gives to young people.

— The progress that has been made, in the last few years, in raising the profile of the needs of this group of children and young people appears to have stalled and the financial climate has resulted in the closure of specialist young witness schemes, significantly those run by the NSPCC.

2. BACKGROUND AND EVIDENCE

2.1 In recent years, a shift in prosecution policy has triggered a 60% increase in the numbers of young witnesses being called to court.\(^\text{359}\) The majority are teenagers, many in their early teens.

It is helpful that “special measures” provisions to assist young witnesses have been extended to those under 18.\(^\text{360}\) However, there remain safeguarding concerns about the way young witnesses are treated in the criminal justice process.

2.2 In Measuring Up?, the largest young witness survey thus far (published by the NSPCC and Nuffield Foundation in 2009), most young witnesses described themselves as anxious in the run-up to the criminal trial and 52% experienced stress symptoms ranging from sleep and eating problems and depression to bed-wetting and self-harming.\(^\text{361}\) More than a third said their school studies or attendance was affected in the run up to the trial: some had changed schools due to intimidation or dropped out altogether. Despite these high levels of stress, the study identified instances in which children, contrary to policy, were told that they could not have therapy before trial. HM CPS Inspectorate (2008) also identified “anecdotal concerns that children may be being prevented from having pre-trial therapy for fear of jeopardising the criminal proceedings.”\(^\text{362}\)

2.3 Over the years, comparisons of young witness studies with national statistics show that the average times to trial in young witness cases remain consistently longer (across youth/magistrates’ court and Crown Court) than for all criminal cases.\(^\text{363}\) This is true even for trials involving young victims covered by the statutory Victims Code.\(^\text{364}\) Delay is recognised as a safeguarding concern: As a basic principle, in cases involving children either as victims or as witnesses, delay should be kept to a minimum in order to reduce, so far as is possible, the levels of stress and worry about the process that the child may feel. From an evidential point of view, the less delay there is the more likely it is that the events will be fresher in the child’s memory.\(^\text{365}\)

2.4 Children’s ability to give their best evidence is also affected by the length of time they wait to give evidence at trial. This routinely exceeds policy targets.\(^\text{366}\) Children waited on average 5.8 hours at Crown Court and 3.5 hours at magistrates’ or youth court. Only 67% completed their evidence on the first day of court attendance.

2.5 Section 24 of the Youth Justice and Criminal Evidence Act 1999, permits eligible witnesses to give evidence by live link from outside the courtroom or from other court buildings or non-court locations. A 2007 survey found that members of the judiciary and lawyers favoured locating remote links at witness support organisations.\(^\text{367}\) However, this option is available in just a few areas. Remote links included those hosted by the NSPCC Devon and Cornwall Young Witness Service in Truro, Plymouth and Exeter where it was the norm for young witnesses not to attend court. These remote links have been withdrawn due to closure of the NSPCC scheme.

\(^{359}\) Different sources indicate that around 48,000 were called to court in 2008–09, compared to around 30,000 in 2006–07. There are no official figures for those who actually give evidence. J Plotnikoff and R Woolfson (2011) Young witnesses in criminal proceedings: a progress report on “Measuring up?”. London, NSPCC and Nuffield Foundation. www.nspcc.org.uk/measuringup, n 3.

\(^{360}\) Sections 16(1)(a) and 21 of the Youth Justice and Criminal Evidence Act 1999, amended by section 98, Coroners and Justice Act 2009.


\(^{366}\) This was favoured by 69% of circuit judges, 85% of magistrates and district judges and 56% of barristers and solicitors. J Plotnikoff and R Woolfson (2007) Evaluation of Young Witness Support: examining the impact on witnesses and the criminal justice system. Ministry of Justice.
2.6 In studies conducted in 2001, 2004, 2007 and 2009, Plotnikoff and Woolfson interviewed a total of 394 young witnesses around the country. In each project, at least half of the children said they did not understand some of the questions they were asked at court; and these were just the ones capable of identifying that they did not understand. In the general population, around half the socio-economically disadvantaged children have speech and language skills that are significantly lower than those of other children of the same age. 10% of children have a clinically recognisable mental disorder, and rates of childhood autism are around one per cent, far higher than previous estimates. More than a million children in this country suffer from speech, language and communication difficulties, with an increase of 58% of young school children identified with the problem in the past five years.

2.7 Children’s entitlement to understand questions and have their answers understood in criminal proceedings is safeguarding concerns just as much as they are the basis of “best evidence”. Article 12 of the UN Convention on the Rights of the Child (1989) places an obligation on courts to create the optimum circumstances in which a child as witness is freed to give his or her account of events. Measuring up? found that 65% of young witnesses reported problems of comprehension, complexity, pace of questioning (too fast) or being interrupted before they had finished their answers. Problems of comprehension occurred across all age groups; teenagers are at particular risk of miscommunication because of unrealistic expectations of their abilities. The Youth Justice and Criminal Evidence Act 1999 provides that an intermediary may facilitate communication at interview and trial with a young witness. If any child witness seems unlikely to be able to recognise a problematic question or tell the questioner that he or she has not understood, then assessment by an intermediary should be considered. Appointment of intermediaries for young witnesses is uneven around the country and is particularly problematic for teenagers who are assumed to have normal communication skills yet may still have difficulty in understanding the language and dealing with complex questioning techniques used in cross-examination.

3. Conclusion

3.1 We urge the Select Committee, in considering the needs of older children and young people who are currently marginalised by a lack of service provision, to include the safeguarding needs of young witnesses in their deliberations. Measuring Up? (2009) recommended that HM Courts Service bring together and publish its young witness policies under the safeguarding “umbrella” (as has been done by the CPS) and agree with the judiciary a package of “consistent witness care procedures”, as recommended by HM Inspectorate of Court Administration.

3.2 The 2003 Green Paper Every Child Matters, the government’s policy to safeguard and promote children’s welfare and improve the following outcomes for children, recognised that safeguarding concerns applied to young witnesses because of the risk of secondary abuse from the court process. It is therefore unfortunate that the Young Witness Thematic Inspection Report, led by HM Crown Prosecution Service Inspectorate, is unpublished and overdue. The young witness report promised by Louise Casey, the Commissioner for Victims and Witnesses had not been published by the time of her resignation. In her letter to the Justice Secretary, Ms Casey said:

“There are other important areas of work which I have not been able to address in the time allowed. In particular you will be aware that I have been concerned about the position of child victims of crime and their treatment as witnesses in the criminal justice system, and the lack of attention and care they receive when we ask them to bear witness for very serious crimes.”

3.3 Many adults, including professionals, find the experience of giving evidence daunting. Young witnesses’ experience of giving evidence and performing an important public duty can be far worse than appearing as a defendant in the criminal courts. As so many young witnesses are also the victim of crime, this cannot be right. They are first and foremost children who’s safeguarding and communication needs are not being met and who need to be able to access specialist support services to assist them. We consider that there should be specialist services to support this group of children and young people in every area, staffed by experienced professionals. Training for those working with young witnesses should encompass induction standards for those working with

369 J Plotnikoff and R Woolfson (2004) In their own words: The experiences of 50 young witnesses in criminal proceedings. NSPCC.
375 www.telegraph.co.uk/education/educationnews/8668117/Growing-number-of-children-dont-know-their-own-name-when-starting-school.html
378 Louise Casey (12 October 2011) resignation letter to Justice Secretary.
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children (both employed and those in the voluntary sector), as required by Local Safeguarding Children Board training standards on safeguarding and promoting welfare.379

April 2012

Written evidence submitted by Julie Haines, Justice for Families

A DISCUSSION OF THE THRESHOLD CRITERIA USED IN FAMILY LAW FOR THE INTERIM REMOVAL OF CHILDREN, AND POSSIBLE REMEDIES

Preamble

This is a short submission centring on one of the three areas prescribed by the Education Select Committee for discussion, namely threshold in care proceedings. I am Julie Haines and work as a senior lay advocate for Justice for Families chaired by John Hemming MP.

My background is in teaching, performing and conducting. However, in 2005, Worcestershire County Council took an interest in my five children based on highly spurious grounds. The children were registered for eight months on the child protection register on the strength of incorrect evidence, after which we managed to get them de-registered without making any changes to our family and without a social worker ever seeing our children.

Eventually, we were totally vindicated. Had we dealt with our local authority the way they wanted us to, it is unlikely our children would have made all the achievements they have.

We have a child studying for a degree at Staffordshire University, one studying A-levels, one a boarding chorister singing in a Midlands cathedral choir, one who has gained a place at Chetham's Music School in Manchester to sing in Manchester Cathedral choir and one (eight years of age) who is still emerging in terms of skill.

I joined Justice for Families in 2006 as a volunteer after giving advice on the net for about two years. I have had the benefit and experience since then of working with parents and grandparents in a large number of varied cases, giving me an oversight possibly unique amongst those outside the legal profession. During this time I have been allowed rights of audience in many courts across England and Wales including the High Court and the Court of Appeal, and I have presented cases to most of the Justices and Lord Justices in the Family Division. I have always been complemented on the assistance I have given and the legal arguments I have deployed against the applicant authorities.

Thus, it is from this basis of practical expertise of dealing with many varied situations that I wish to make a contribution for consideration to the Education Select Committee.

Threshold Criteria

Proving the threshold of significant harm to the child has been met is key to Children's Services when considering taking a child into interim care via an Interim Care Order or an Emergency Protection Order. For the courts, looking at whether the threshold is met is fraught with difficulties. For the parent accused of causing harm to the child by the local authority, defending such an action seems an insurmountable task and for the local authorities wishing to prove their case, it seems that the advantage is on their side. Thus, the starting point is statute:

The Children Act 1989 s 31 states:

1. On the application of any local authority or authorised person, the court may make an order—
   - (a) placing the child with respect to whom the application is made in the care of a designated local authority; or
   - (b) putting him under the supervision of a designated local authority

2. A court may only make a care order or supervision order if it is satisfied—
   - (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 to him; or
     - (ii) the child's being beyond parental control.

In considering the above it is clear that Parliament has given the courts free reign to define the term “significant harm” within case law authorities and has not deemed it necessary to provide a definitive meaning within the Children Act 1989. There is no check list of harm, no clues as to what the courts could be looking for. This is a problem for parents, as they may feel that they are meeting all their children’s needs and parenting in the way they see others parenting within their own demographic subset.379

There are a number of criteria for defining harm to a child, namely: emotional, neglect, sexual and physical. Most of these are fairly self-explanatory to the lay person, however some of these as they are currently posed to the parent do not fall within the normal understanding and definitions that a person on the street would recognise. Thus the playing field is certainly not a level one with the balance tipping on the side of the applicant council.

**Significant Harm Due to Neglect**

It could be argued that some aspects of neglect do not give rise to the child being put at risk of significant harm such as an untidy or unacceptably dirty home environment or chaotic life style, provided the basic needs of the child are met. Most parents would say that they work on a basis of “my home, my rules”.

Another problem for the courts to consider is that of cultural and cultural anthropological issues. For example, parents moving from parts of Africa may not realise that they cannot leave their children home alone, or understand that the law on chastisement in their own country may well be very different from the law here in the United Kingdom. Such cultural differences are never really explained to the parent, nor are they taken in to consideration by the courts who apply the law to the maxim of “our society, our rules”.

However the serious neglect of a young child can have negative effects on his or her ability to form attachments and can be linked to major growth impairment and intellectual development. The impact of neglect varies depending on how long a child has been neglected, the child’s age, and the variation of neglectful behaviours the child has been experiencing. Rarely is it the case that sustained neglect over the whole or most of the child’s life is an issue. Neglect appears in a child’s life when a major family issue has taken hold, such as depression and very commonly post natal depression in mothers. The loss of a job can bring on neglectful attributes in parenting. Bereavement and debt are other circumstances where child care may fall below accepted norms for a time in the child’s life. Yet these are variables that are sadly not taken in to full consideration by the courts and not dealt with on a practical level. It seems the “services” aspect of the social service and children’s services departments are missing. People who ask for “services” from their local council end up with their children being permanently taken by the State. I have seen this happen on a number of occasions during the course of my work with Justice for Families.

**Significant Harm Due to Emotional Abuse**

Most people would not realise that a domestic argument between parents or witnessing a parent’s distress during a depressive episode are considered to be emotional abuse. If asked the question of what they understand by emotional abuse, then the answer that would likely come back is that they would assume that undermining the child’s confidence is emotional abuse.

Emotional abuse is not a reason in itself to take a child from their parents. Yet in *Re C & B (Care Order: Future Harm)* [2001] 1 FLR 611 this was exactly what happened. At the interim stage there was no threshold to take the child in to care. Yet a thriving 10 month baby ended up residing in local authority care. Hale LJ heavily criticised the local authority to for its attitude, the sense of which is a “grab now and ask questions later” policy.

The other criteria for threshold to take a child in to care, that of risk of sexual harm and physical abuse are fairly self explanatory and will not be discussed here directly.

**Interim Removal**

There are a number of authorities setting out the remit for the interim removal of children from their families.

In *Re O (Supervision Order)* [2001] 1 FLR 923, Hale LJ emphasises that:

> The court should begin with a preference for the less interventionist rather than the more interventorionist approach. This should be considered to be in the better interests of the children … unless there are cogent reasons to the contrary …”

In *Re C & B (Care Order: Future Harm)* [2001] 1 FLR 611, (as previously mention above), the applicant authority perceived harm to the child derived from the mother’s personality traits which in stressful situations, including conflict with the father, led to her becoming irrational, aggressive, emotionally demanding and incapable of putting the children’s needs before her own (para 15)). At the time of the interim hearing (resulting in the child’s removal) there was no evidence of physical harm; on the contrary, the evidence was that he was thriving.

In *Re G (Care: Challenge to Local Authority’s Decision)* [2003] 2 FLR 42, Munby J held:

> “The fact that a local authority has parental responsibility for children pursuant to s 33(3)(a) of the Children Act 1989 does not entitle it to take decisions about children without reference to, or over the heads of the children’s parents. A local authority, even if clothed with the authority of a care order, is not entitled to make significant changes in the care plan, or to change the arrangements under which the children are living, let alone to remove the children from home if they are living with their parents, without properly involving the parents in the decision-making process and without giving the parents a proper opportunity to make their case before a decision is made. After all, the
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"fact that the local authority also has parental responsibility does not deprive the parents of their parental responsibility."

If a threshold is being made out for the interim removal of children then the interference with family life needs to be considered. In Re B (Care: Interference with Family Life) [2003] 2 FLR 813, Thorpe LJ held:

"the judge may not make such an order without considering the European Convention for the Protection of Human Rights and must not sanction such an interference with family life unless he is satisfied that that is both necessary and proportionate and that no other less radical form of order would achieve the essential end of promoting the welfare of the children."

Yet family life in many cases is all but forgotten by the courts citing the “paramountcy principle” of the Children Act 1989 from the welfare checklist. In the balancing act undertaken by the judge, he needs only to cite this principle and state that he has considered the Human Rights Act 1998, though even this is frequently neglected.

**Unquantified Risk**

No risk identified to a child should be left as unquantified. To enable this, the court should ask itself two things.

1. Having identified a risk, what is the risk to the child?
2. Can the risk be managed, and if so, how?

**Case Study 1**

This is a case I was directly assisting towards the end of the court of first instance hearings and involves two caring parents and their two boys who shall be referred to as T and K. At the age of approximately nine months K sustained two possible injuries, one to the leg as a metaphyseal fracture and a “boggy swelling” to the side of the head. The possibilities for the pool of perpetrators were the two parents, two day carers and the carers’ two teenage children. The carers and their children were ruled out despite having both boys in their care for considerable amounts of time. No reasons were given for the exclusion of the carers’ children from the pool of perpetrators. Thus, only the parents were considered to be possible perpetrators of one and maybe two injuries to K. Both denied even knowing about it as when the swelling to the head was discovered the child was taken to the hospital. The problem for the court was that the parents were regarded as an “unquantified risk” to both boys. At that point, the possible risk both parents posed should have been quantified. This, for whatever reason, did not happen and the boys were made subject to a placement order in September of last year. They are still in long term foster care after approximately 39 months.

The incongruity of this situation means a life long nightmare for the parents and puts both boys at risk of future significant emotional harm. Assuming that one parent was responsible for the injuries then the innocent parent has lost both of the children. If neither parent was responsible then four innocent people will suffer: both the parents and the children.

The court was not saying that the parents were an “unquantifiable risk” just that they posed an “unquantified risk”. In this regard, the threshold for harm could not have been met as the court was dealing with a complete unknown, whereas a threshold document deals with known variables. If family law used a risk based approach such as is used in the insurance industry, a local authority could more accurately assess the probability of harm to a child with a greater confidence level than just having a pool of perpetrators based on the balance of probability.

The likelihood of significant harm occurring to a child could be quantified and managed so that the parent and child can remain together. For this to happen there needs to be a comprehensive probability model developed. For example experts for the local authority can say that the likelihood of harm to a child is “minimal”, but that kind of value judgement is meaningless when such a term may mean something different to everyone in the court room.

Additionally the cost to the tax payer in managing such a case so that children can remain with parents is minimal, compared to the costs of long term foster care, which in the first case study will have already exceeded the £150,000 mark.

**Case Study 2**

I another case I assisted with in Birmingham, the step father was found, in a finding of fact hearing, to have sexually abused his step daughter. Mother did not accept the allegations and supported her husband. They had a boy. The child resided with mother whilst the parents were living apart as part of a working agreement. No harm came to the child, yet when an application for an ICO was made the boy was moved in to care. What tipped the balance for the judge was a psychological report that stated that father was “likely” to sexually abuse his son. Under cross examination by myself the psychologist claimed that since the father had only abused a girl the risk of abuse to the male child was about 25%, and hence not a “likelihood” of harm at all. Nonetheless, the mother lost her younger child as it was deemed by the court that she would fail to protect him.
CASE STUDY 3

In this study, two parents and two children are involved, one with special needs. In October 2011 the county council took the children into care on without any legal authority. The children were returned to their family’s care the next day once it was established that they were taken illegally by the council with the police in attendance at the home.

The parents have always maintained that they cared for the children with no issues of harm, yet the council made an application for an ICO which was granted in January this year. There is no evidence of harm, physical or otherwise, just the merest suggestion that the children aged 12 and 13 years of age may be unhappy about the fact that naturism is practiced within the home. There have been two allegations of sexual abuse perpetrated by the father over a period of five years. Both allegations were investigated by the police and found to have no substance. Therefore, the suggestion by the applicant authority is that the girl aged 12 (nearly 13) years of age is at risk. No risk has been demonstrated and yet both children have been removed from the family home. The children are able to speak for themselves, yet the guardian never saw the children and has not sought their views, and the court has refused permission for the older child to appear a witness.

If there was a probability model in place of the kind used in the commercial fields, then in all likelihood the children in these three cases could have remained safe within their own families, as the alleged risk could have been managed.

CONCLUSION

To conclude, it is very clear to all that more needs to be done to keep children and families together. It is also clear that any perceived risk needs to be quantified and a risk based approach adopted. Once that has been established, then the risk needs to be managed and monitored. Over a period of time to be determined in each case, the management of the perceived risk can be lessened as the longer the time period the less likely the harm is to occur.

I would urge the members of this committee to read the transcript of the lecture given on behalf of NYAS by Mr Justice Ryder in 2007 entitled “The Risk Fallacy—A Tale of Two Thresholds”.

The threshold debate would be further advanced by the application and adjudication of a jury, as in the criminal courts. The criminal standard would not necessarily need to be applied, however the safeguards that a jury can provide would mitigate against the allmighty judicial discretion. The exercise of judicial discretion by one person, however experienced cannot indemnify the respondent parent against bias. The use of a jury (and the costs involved) would ensure that the need for litigation against the parent is warranted and that the “on the balance” criteria for judicial decision making against the parent is fair. Obviously there are privacy considerations to factor in, but this as a practical problem could be worked through so as to make the proposition manageable. Juries are already under a duty of confidentiality.

Every member of society has some experience of parenting, whether through the raising of children themselves, or simply though their own experience of childhood. A jury is fully capable of deciding on its own terms whether a situation which is brought before it is abusive or not. Such decisions are better made according to the norms of our own society than by the writers of sociological text books.

APPENDIX

Lecture given on behalf of NYAS by Mr Justice Ryder,
Family Division Liaison Judge for the Northern Circuit,
on 8 November 2007

THE RISK FALLACY

A Tale of Two Thresholds

If a child is removed from a parent on the basis of a finding or allegation that is wrong, a tragedy is caused both to the child and the family. If a child is not so removed and then suffers death or really serious harm, no less a tragedy ensues for all concerned. Consider also the unknown perpetrator cases, such as Lancashire County Council v B [2000] AC 147 at 149 E where it was said at first instance:

“[There is an] obvious dilemma in human terms. If the (threshold) criteria are met and orders are made I am exposing one child to the possibility of removal from parents who are no risk and have done no wrong …. if the applications are dismissed then I will undoubtedly be causing one child to be returned to a parent, or parents, one or both of whom are an obvious and serious unassessed risk”.

Despite a number of attempts by the Court of Appeal and the House of Lords to interpret the child protection purpose of the Children Act 1989 in a way that is compatible with the human rights principles that informed its drafting, I am going to suggest that a formula for the determination of the threshold in section 31, the facts in issue and the component elements of welfare in section 1 (3) has eluded their Lordships’ House.

As we approach the introduction of a new and more coherent case management process that is designed to identify the key issues and help to narrow and resolve them within a timetable for the child I believe it is both
appropriate and necessary that we also re-examine our risk assessment and decision making process. In particular, I seek to suggest that we need to have a measured and rational debate as to whether in the determination of a likelihood or risk of harm it is always necessary for the court to make findings of fact to the civil standard of proof ie on the balance of probabilities.

The origin of the stark dilemma that underpins the jurisprudence of the Children Act 1989 is a legal fiction most recently described by Lord Nicholls of Birkenhead in Re O & N; Re B [2003] 1 FLR 1169 at para [10]:

“Courts and tribunals constantly have to decide whether an alleged event occurred. The general rule is that if the likelihood that a past event occurred is proved to the requisite standard the law regards that event as definitely having happened. If not, it is treated as not having happened.”

There is no sophisticated rationale for this rule nor is the fiction set in stone. As respects different species of decision the law provides different solutions both as to what the decision maker may take into account and to what standard of likelihood a past event must be proved or a future event forecasted. For example, we protect juries from clearly relevant material that is thought to be more prejudicial than probative and the legal context may permit decision making in accordance with a variety of standards: the Children Act itself is a good example, in the different standards applicable to section 47 investigations, interim care orders and full care orders.

As Lord Nicholls reminds us, the legal context is determined by legal policy, statutory or otherwise. It is accordingly susceptible of change. Furthermore as the policy has been set by the judiciary not Parliament, it is still in the hands of the judiciary to re-consider whether the solution fits the problem.

The problem is how to balance the need to protect families from any disproportionate interference by the state with the imperative to protect children against harm.

Risk management in everyday life usually has regard to the seriousness or severity of the consequence if protective or preventative steps are not taken. Accordingly, such a step is more likely to be taken where the harm or risk of harm would be very serious on the basis that the consequence cannot sensibly or safely be ignored. In social care situations as in other aspects of life, assessments of risk are carried out every day and there are tens of thousands of such assessments each year. With very few exceptions risk assessments do not depend on findings being made by a court, even less so are the assessors expected to come to their conclusions on the basis of their own judgment as to the harm or risk of harm asserted by reference to the civil standard of proof.

The opinion evidence of experts is the consequence of the assessment processes and techniques that they use. It will almost certainly be the case that it is not appropriate to characterise, for example, a paediatric or psychiatric risk assessment as being a conclusion to which the civil standard of proof applies in just the same way that a social care assessment, for example in accordance with the Framework for the Assessment of Children in Need and their Families TSO (2000), is neither based upon nor results in a conclusion on the way that a social care assessment, for example in accordance with the Framework for the Assessment of Children in Need and their Families TSO (2000), is neither based upon nor results in a conclusion on the balance of probabilities: see for example Re S (Sexual Abuse Allegations: Local Authority Response) [2001] EWHC Admin 334, [2001] 2 FLR 776 per Scott Baker J. The task of determining facts to a standard of proof is for the court or a principle that was re-iterated in the House of Lords by Lord Hope of Craighead in Dingley v Chief Constable of Strathclyde Police (2000) 55 BMLR 1 (9 March 2000).

As Lord Nicholls remarked at para [18] of Re O and N local authorities would be prevented from carrying out effective and timely risk assessments if they could act only on the basis of proven facts.

It can be argued that the core assessment and any specialist assessments that inform it which are likewise not dependent on proof of fact (eg a doctor’s differential diagnoses and prognoses) are consistent in their method of preparation and analysis with the local authority’s duty to investigate under section 47 of the Act. The trigger under section 47 is having reasonable cause to suspect that a child is suffering or is likely to suffer significant harm and accordingly reasonable cause and an assessment that is not dependent upon proven fact are compatible concepts.

I would suggest, however, that the fact that the test is different in section 31 from that in section 47 is hardly a sufficient rationale for the court in contested cases to have to deconstruct and reconstruct every assessment to examine whether all 22 dimensions and three domains of the assessment are well grounded in facts that are susceptible of proof to the civil standard and likewise to unpack every differential diagnosis and prognosis. The fact that we are asked to do so in order to follow the ratio of the majority of the House in Re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 565 (otherwise known as Re H & R) is one explanation for the increasing complexity of hearings in even the most simple of disputes.

In this context it is perplexing that the approach laid down in Re H & R to the making of findings about inflicted harm and the establishment of a likelihood of harm tends to work in the opposite way to the general approach to risk management. This is because the approach in Re H & R overtly includes the proposition that the more serious the allegation the less likely it is to have occurred, which necessarily militates against a finding being made to a higher standard and correspondingly leads to the child being less well protected.

That proposition is a component of the overall approach to evidence arising out of Re H & R which it is perhaps wise to recollect. For the purposes of this discussion there are 8 propositions I wish to highlight:
1. The test to be applied in determining the facts in issue is the civil standard, namely the balance of probabilities which means that a court is satisfied an event occurred if the court considers that on the evidence the account of the event was more likely than not.

2. The court is not determining whether there is a real possibility that the relevant event occurred but whether it is more likely than not that it did so.

3. Where a serious allegation is in issue the standard of proof is not higher but the court will have in mind as a factor that the more serious the allegation the less likely it is that the event occurred and hence the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability: the more improbable the event the stronger must be the evidence that it did occur.

4. It is perhaps of note that Lord Nicholls recognised the essential contradiction within his own analysis when he said:

   “In my view, therefore, the context shows that in section 31(2)(a) likely is being used in the sense of a real possibility, a possibility that cannot sensibly be ignored having regard to the nature and gravity of the feared harm in the particular case.” (Re H and R at 585F)

   That, with respect to the House, is the key to the resolution of the problem. A key that was reflected in the previous protective practice of the wardship jurisdiction.

5. The likelihood of future abuse is not to be proved on the balance of probabilities: one cannot say as a fact that something in the future will happen: a real possibility will suffice.

6. It is settled law that for a real possibility to be established the harm that is feared need not have happened in the past. However, the court must reach its conclusions on the evidence before it, unresolved judicial doubts and suspicions can no more form the basis of a conclusion that the second threshold condition in section 31 (2) (a) (ie likelihood) has been established than they can form the basis of a conclusion that the first has been established.

7. If the issue before the court concerns the possibility of something happening in the future: a decision by a court on the likelihood of a future happening must be founded on a basis of present facts and the inferences likely to be drawn there-from.

8. The range of facts that may be relevant to the question of the infliction of harm or its likelihood are infinite eg relationships, threats, behaviours and so on. Facts which are minor or even trivial if considered in isolation, taken together may suffice to satisfy the court of the likelihood of future harm.

I ought to add that the opinion of an expert is evidence and an expert can express an opinion on an ultimate issue and that provided the court does not lose sight of the fact that the expert advises and the judge decides, the judge can put such weight on the opinion of an expert as he thinks appropriate. A judge who requests an opinion from an expert does so essentially because that expert possesses a skill and expertise that the court does not have and accordingly the court should give reasons for the rejection of that opinion in any conclusion to that effect.

This is not the place for a digression into the impressive overview of evidential jurisprudence that can be found eg in A County Council v K D & L [2005] 1 FLR 851 and Re R (Care: Disclosure: Nature of Proceedings) [2002] 1FLR 755 both per Charles J, but it would probably suffice to say that had one of the legacies of the wardship jurisdiction not been to try and override the law of evidence by reference to the paramountcy principle to achieve a just result (which historically had never been a justification that was permitted to achieve that result) the existing conundrum might never have arisen. Likewise, had the elegant argument put forward by Mr James Munby QC (as he then was) in Re H & R been heeded, a different result might have obtained.

I have touched on wardship practice which I ought to explain for the majority of the audience who will no longer have had that experience. In the wardship jurisdiction and at least up until 1987 it is arguable that the test for determining whether the jurisdiction should be continued, which was the only jurisdictional threshold for the wide and almost unencumbered discretion to be exercised, was whether there was a real possibility of harm. As Purchas LJ observed in Re F (Minors) [1988] 2 FLR 123 at 128 B—D:

   “I do not think that a probability has to be shown but a real possibility. In that way, the interests of the child will be safeguarded”.

Whether there was a real possibility of a past event having occurred or a future event taking place had to be based on evidence ie it could not be speculation or a fanciful possibility but a real possibility was sufficient. However, in H v H: K v K [1990] Fam 86 the Court of Appeal disapproved of the application of that standard to the proof of past harm. Croom-Johnson LJ described real possibility as a standard of proof for past harm to be a fallacy. He distinguished Re F on its facts and by reference to other contemporaneous authorities that demonstrated that in children cases past harm should be proved to the civil standard. He accepted that on the facts Re F was a case about the future and accordingly that the test was correctly described in that context as a real possibility. Butler Sloss LJ went further, justifying her analysis with the phrase “the court can only act on evidence otherwise the judge would be dispensing palm tree justice”. She described the very circumstance later taken up by Lord Nicholls in Re H & R where the ultimate issue cannot be proved to the civil standard but a collection of other facts might give rise to a real possibility of harm in the future and if thereby the child
is in a potentially abusing situation the judge will take steps to safeguard the child. She was, however, careful to distinguish between evidence and findings.

That left open the question of whether a real possibility as to the future had to be based on facts found to the civil standard even if the ultimate fact of harm in the past could not be proved or evidenced.

It did not of course take long for the evidential approach in Re H & R to cause difficulties and for its strict application to be re-considered. By 1999 Lancashire CC v B had been heard at first instance and in the Court of Appeal. In order to rid the system of what Lord Nicholls described as the dangerously irresponsible approach (Lancashire CC v B @ 165G) of cases being dismissed for want of proof of perpetration to the civil standard their Lordships approved and developed two related concepts that were described by Walker LJ (as he then was) in the Court of Appeal decision in the same case, namely:

(a) that responsibility, culpability or blameworthiness are not relevant to the threshold question; and
(b) that the causation of harm is the identification of the perpetrator is not a necessary component of the threshold.

By emphasising that the causal connection in the attributability component of the threshold is merely a passive not an active element and that the reasonable standard of parental care necessary for the child is an objective question, Lord Nicholls was able to conclude (@162 C—D) that the absence of a reasonable standard of parental care need not imply that the parents are at fault. Accordingly the construction of “care given” was widened to include any of the shared carers with the inevitable consequence that there may be no more than a possibility that the parents were responsible for inflicting the injury on the child. That has now been extended to the test to be applied to the determination of the size of the pool of possible perpetrators (see North Yorkshire County Council v SA [2003] 2 FLR 849).

In 2003 the conjoined appeals in Re O & N and Re B reached the House. The essential fiction with which we began this discussion was in stark relief. In proceedings where perpetration remained uncertain ie there was a real possibility that either parent could have harmed the child but it could not be proved to the civil standard which; how does the court proceed to assess risk of harm for the purposes of the welfare question in section 1(3)e)?

The threshold was satisfied in accordance with Lancashire CC v B and neither parent could be exculpated on cogent evidence proved to the civil standard. There remained a real possibility of perpetration that could not be proved to the civil standard (and therefore just to recollect, that was not a fact that exists in law). Could that be relied upon in the judicial assessment of risk? The answer is provided in the opinion of Lord Nicholls which is, if I may say so, so far reaching if taken to its logical conclusion.

In simple terms, the possibility of perpetration is a conclusion on the evidence that is to be taken into consideration when the court considers the welfare question. Lord Nicholls again used strong language in defence of this derogation from the Re H & R approach:

“it would be grotesque if such a case had to proceed at the welfare stage on the footing that, because neither parent, considered individually, has been proved to be the perpetrator, therefore the child is not at risk from either of them”.

There was raised before the House the obvious question of logic: if it is right as being in pursuit of the child protection purpose of the legislation to consider unproved perpetraions as a real possibility for the purposes of welfare then why not also carry across equally salient conclusions as to the real possibility of harm? At paragraph [31] Lord Nicholls hints at the argument that it would not be right to exclude from consideration at the welfare hearing all of the circumstances (my emphasis) including the possibility of perpetration. As he said, to do otherwise risks distorting the court’s assessment. And at paragraph [32] he entreats judges at fact finding hearings to give a judgment on the likelihood of perpetration to assist the assessments by the court and professionals alike.

What then is the logical distinction between a distortion caused by a failure to consider the real possibility of harm and a real possibility of perpetration of harm? The idea that perpetration is irrelevant to welfare because blameworthiness is irrelevant to threshold is not of course sustainable. You only have to consider carers who separate so that the court has to choose between an innocent and guilty parent. Likewise the nature and extent of harm itself.

At paragraphs [37] and [38] of the Re O & N Lord Nicholls does not discount consideration of the possibility of harm at the welfare stage. Although a strict application of Re H & R would prevent any consideration of harm that has not been proved, what Lord Nicholls suggests is that the court should proceed on the footing that the unproven allegations are that and no more than that. That gives the evidence an equivocal status. It was said that this approach accords with the earlier decision of the Court of Appeal in Re M & R (Child Abuse: Evidence) [1996] 2 FLR 195 but all that was said in Re M & R was that it would be extraordinary if evidence that was insufficient to satisfy section 31(2)a) should nevertheless be sufficient to satisfy section 1(3)e). And that, with respect, begs the question as Re M & R simply followed Re H & R and Butler-Sloss LJ was careful to restrict her conclusion to the same example, namely:

“if the court concludes that the evidence is insufficient to prove sexual abuse in the past, and if the fact of sexual abuse in the past is the only basis for asserting risk of sexual abuse in the future then
it follows that there is nothing (except suspicion or mere doubt) to show a risk of future sexual abuse” [Re M and R @ 203D].

None of this answers the problem which arises out of the legal fiction that the inability to prove a fact to the civil standard means the fact in question does not exist. In two reported cases the High Court has suggested that Lord Nicholl’s analysis as to the application of a real possibility might be extended to include real possibility of harm. The first was A County Council v A Mother, A Father and X, Y and Z (Children) [2005] FLR 129 per Ryder J and the second was the decision of Charles J in Birmingham City Council v H & S [2005] EWHC 2885. Neither case was subsequently reported in respect of the welfare hearings because they resolved and the point was not decided on the facts. Further, although I would strongly oppose the fashionable view that the law of evidence can be overridden by mere reference to paramountcy and on another occasion could give ample justification on the authorities for that view, it was Lord Nicholls who set out the legal policy justification for considering all the circumstances at paragraph [24] of the Re O & N. There he said:

“This has long been axiomatic in this area of the law. The matters the court may take into account are bounded only by the need for them to be relevant, that is, they must be such that, to a greater or lesser extent, they will assist the court in deciding which course is in the child’s best interests. I can see no reason of legal policy why, in principle, any other limitation should be placed on the matters the judge may take into account when making this decision. If authority is needed for this conclusion I need refer only to the wide, all-embracing language of Lord MacDermott in J and Another v C and Others [1970] AC 668, sub nom J v C (1969) FLR Rep 360, at 710–711 and 383 respectively.”

Let me go back to first principles in order to conclude with a solution. I emphasise there will be other solutions that may be better and that it is in the nature of a lecture that the safety net of applying an idea to the facts in issue is missing. First of all in relation to the legal fiction of proof, one should not forget, most particularly I would suggest in a process that is in part an inquisition not just an Article 6 compliant adversarial trial, that a real possibility on the evidence is something relatively substantial. It is not a mere suspicion or lingering doubt. It is not fanciful. To return to the example of the two perpetrators who have separated after harm is caused: it reflects the fact that there is clear evidence that one or both of them inflicted the serious harm and the court is simply unable to penetrate the fog of accusation and counter accusation to decide who. Not all harms are immediately visible or susceptible of pathognomic diagnosis as distinct from differential diagnosis. To exclude the real possibility of such harm which in reality is what many a differential diagnosis or care assessment concludes is to do a disservice to the child and depart from the intention of Parliament.

Secondly, does that mean that the court should no longer strive to find facts to the civil standard? I would suggest that the many distinguished family judges who have asserted to the contrary are on balance right. It would be just as grotesque for the court to permit innocent parents as carers of children to be left under the disability that such uncertainty causes which in itself causes harm to the child. Furthermore, it is difficult to argue against the proposition that key issues of fact should be determined wherever possible to the civil standard because that provides the protection against arbitrary interference by the state in family life and clarity as to the factual circumstances with which a child thereafter has to live.

Thirdly and where I depart from Re H & R in relation to fact finding is that I would suggest that it is almost inconceivable that in the circumstance that there is insufficient cogent evidence on the ultimate issue to find facts, that it is possible to construct a logically consistent threshold as to the future risk of the same harm based only on satellite facts proved to the civil standard. A judge after all has available to him all of the conventions of evidence: the ability to find secondary facts and the inferences reasonably to be drawn there from (Jones v Great Western Railway Company (1930) 144 LT 194) and to examine the opinion evidence of assessors to see the extent to which the opinion is supported by the evidence (the classic exposition of which is that of Stuart-Smith LJ in Loveday v Renton [1990] 1 Med LR 117 @ 125) but if on completion of that exercise, the primary fact in issue cannot be inferred then without anything more on a Re H & R approach a future event is unlikely to be forecasted and the second protective limb of the threshold is rendered of no effect.

That suggests that to be effective the second limb should be satisfied on a different basis namely the likelihood of harm should be a real possibility based on evidence not proven facts. There would then be no need for any illogical distinction to be drawn between likelihood in section 31(2) and risk in section 1(3)(e) and real possibilities could be considered by the court. That would bring social work assessments and expert opinions into line with the court’s assessment process. That also accords with the approach of Kennedy LJ who dissented in the Court of Appeal in Re H & R and Lords Browne-Wilkinson and Lloyd of Beswick who delivered dissenting opinions in the Judicial Committee. For my part I believe they were right. The key to the solution is Lord Lloyd’s description of the fallacy of the majority (@581):

“The likelihood of future harm does not depend on proof that disputed allegations are true. It depends on the evidence. If the evidence in support of the disputed allegations is such as to give rise to a real or substantial risk of significant harm in the future, then the truth of the disputed allegation need not be proved” (and I would add, for the threshold to be satisfied).

We have become transfixed in the headlights of proof to the civil standard. There is nothing wrong with a legal policy of risk being established on the evidence to a different standard. I also agree with the dissenting voices that assessment of the evidence is a one stage process. Many of the problems associated with our fact finding process have been generated out of the erroneous view that the threshold are conditions to be satisfied
in the sense of grounds for the care order. If any authority is needed that this is an inappropriate approach it can be found in the judgment of Walker LJ sitting in the Court of Appeal in the Lancashire CC v B @ 149G where he quoted with approval Lord MacKay of Clashfern LC giving the Joe Jackson Memorial Lecture in April 1989 [1989] 139 NLJ 505

"the requirement in the Bill that the court be satisfied that there is significant harm or the likelihood of such harm to the child arising from an absence of reasonable parental care …is NOT a ground or a reason for making a care or supervision order. Those conditions simply set out the minimum circumstances which the Government considers should always be fount to exist before it can ever be justified for a court even to begin to contemplate whether the state should be enabled to intervene compulsorily in family life."

We perhaps should remember that in only 15% of all care proceedings that are issued is there a contested threshold and that in the vast majority of social work cases assessments are relied upon without recourse to the court.

In summary, I am of the view that the following propositions need to be tested on the facts of an appropriate case or cases with a view to the Court of Appeal and their Lordships’ House being asked to re-consider the law:

(a) The allegations of fact that give rise to the need to make a welfare assessment ie the key issues necessary to satisfy the threshold and inform the plan for the child must be identified in every case.

(b) There should be a progression of reasoning as follows: first the identification of the evidence ie the factors in favour of and against the competing conclusions; Second an assessment of the weight ie the cogency or quality of that evidence and third a conclusion with explicit reasoning.

(c) The court should strive to reach a conclusion in respect of each key issue on the balance of probabilities but where it cannot it should describe the evidence it relies upon and the judicial inferences it makes and where it comes to a conclusion that a real possibility exists it should say so and that should form not only part of the second limb of the threshold but also part of the section 1(3) risk assessment.

(d) The court process should be a single stage within which two questions are answered, the jurisdictional question and the welfare question: both in the context of an overall rather than a partial or sub-divided review of the evidence and the risk assessment that is required of the court.

There are other good reasons, substantive and procedural for a reconsideration of our process. If out of a review of our approach to evidence we constrain split hearings to single issue cases that can be determined by a judgment on the key issue and the most complex factitious cases where no realistic assessment can take place without the story being re-written by the court then in my view that will be a considerable achievement. In any event I believe a decision as to the need for a split hearing can rarely be taken in early case management. It usually needs the context of assessment evidence that is not generally available until the Issues Resolution Hearing. On an altogether different plane, it is arguable that we need to re-consider Re H & R in the light of the developing Article 2, 3, 6 and 8 jurisprudence so that our decision making process remains Convention compatible.

A more reasoned and global approach to the process of judicial assessment of risk may have the effect of more cases satisfying the threshold for jurisdiction but I would hope that the renewed emphasis of the senior judiciary on whether the harm that is asserted can be regarded as significant and also on the need to show imminent risk of really serious harm before a child is removed under an EPO or ICO will focus minds on the whole process of assessment and protection.

The most recent example of the latter is Re K and H [2007] 1 FLR 2043 CA. A good example of the former is the decision of Hedley J in Re L (Care: Threshold Criteria) [2007] 1 FLR 2050 where he said:

“The current legal starting point was that children were best brought up within natural families: it followed that society must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent, and that some children would experience disadvantage and harm, while others would flourish in atmospheres of loving security and emotional stability. It was not the provenance of the state to spare children all the consequences of defective parenting: the compulsive powers of the state should only be exercised when the significant harm has been made out”.

If ever there was a good place to stop that is probably it.
EXECUTIVE SUMMARY

The purpose of this submission is to highlight as briefly as possible for the committee some of the issues relating specifically to “thresholds” that I consider essential for the committee to enquire into further before reaching conclusions. I base these thoughts on my professional experience over many years. In making this submission it is not my intention to be appearing to be advocating a particular outcome, but to highlight the issue.

THE SUBMITTER

I have worked all my professional life in Social Work in particular work involving children and young people concentrating almost entirely on Adoption and Fostering. I worked initially as a Social Worker with a Local Authority in the North East of England, then for over 15 years I was the North East Regional Consultant for the British Association for Adoption and Fostering. During the past 15 years I have been the independent Chair of Adoption Panels and Permanency Panels for Voluntary Adoption Agency’s and Local Authority’s. I currently am the Independent chair of two Local Authority Adoption Panels. I have also in the past authored a number of independent reports for the Courts mainly in Care Proceedings.

CARE ORDER THRESHOLDS

1. It is very common for a time period to elapse of at least six months and more typically a year or over between the making of an Interim Care Order and a “final” Care Order.

2. The threshold required to be satisfied for a Court to make an Interim Care Order is at sec 38 (2) of the Children Act 1989. The Court has to be satisfied that “there are reasonable grounds for believing that the circumstances with respect to the child are as mentioned in section 31(2)”. It is important to highlight that technically the Court is adjourning an application for a Care order in considering whether to make an Interim Care Order [sec 38 (1)(a)].

3. Section 31(2) applies when the Court considers the making of a Care Order: that the child concerned is suffering, or is likely to suffer, significant harm and that the harm or likelihood of harm is attributable to 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 to him …

4. In other words the test for the interim order is of a lower threshold (“reasonable grounds for believing” only being required).

5. The vast majority of birth parents find themselves going along this path which the committee may or may not conclude is a fair process.

6. It is true that Sec 1 of the ‘89 Act makes the welfare of the child the Court’s paramount consideration. But the welfare test itself is not the condition that has to be satisfied—that is either Sec 38 or Sec 31.

7. To illustrate the problem briefly I can best give an example from my own practice now some years ago. I worked in a very deprived inner city area. It could have been be argued that the welfare of the majority of the children in that area could be enhanced (nutrition, stimulation, educational attainment etc) by placing them with foster carers in a very much more affluent area less than six miles away.

8. I suggest that the committee form a view as to the adequacy of the (much referred to) “welfare” concept alone in determining whether a child should be compulsory removed from their birth parent(s) and placed for adoption.

9. The committee has been given evidence for example by Barnardos (at question 3.2 of their written submission) where they refer to the “welfare principle” and state that the “legitimacy of this principle has not been directly challenged by the European Court of Human Rights or by the UK courts under the Human Rights Act”. I would suggest to the committee that the situation is less clear and would refer the Committee to for example a paper given to the “Joint Council of Europe and European Commission Conference” entitled “Challenges in Adoption procedures in Europe—ensuring the best interests of the child” in 2009 by Brian Sloan, Lecturer in Law, Kings College Cambridge.

10. He offers the view that:

    The English provisions on parental consent to adoption and its related procedural hurdles are potentially open to challenge under Article 8 of the European Convention on Human Rights, which protects the right to respect for private and family life.

    In Görgülü v Germany the European Court of Human Rights emphasised that the severance of family ties could be justified only in “very exceptional circumstances”.

    That said, the European Court’s attitude to adoption has been described as “rather ambiguous”.

    Whether an adoption against parental wishes breaches Article 8 is highly dependent on the facts of the case.
The margin of appreciation allocated to states plays a pivotal role, and the extent of the child's relationship with the biological parent in question may be a crucial factor.

11. He concludes:

I have argued that the circumstances in which parental consent will be Dispensed with and related procedural requirements may leave doubts as to English adoption law’s Compatibility with Article 5 of the Revised Convention on the Adoption of Children because of a Disproportionate focus on child welfare, even if English Law can formally be saved by Article 18.

12. In respect to Adoption the critical “threshold” wording is the condition required for the Court to make a Placement Order under Sec 22(1) of the Adoption and Children Act 2002 ie Sec 21 (2)(b): the court is satisfied that the condition in section 31(2) of the 1989 Act (conditions for making a care order) are met and [in sec 21(3)(b)] that the parents consent should be dispensed with. The welfare of the child is again paramount in section 1(2) but this time “throughout his life”. This in my view is an important addition and leads on to the Courts or Adoption Agency’s duty to fully consider the whole of Section 1 (before coming to a decision relating to the adoption of a child including [at section 1(4)(e)] any harm which the child has suffered or is at risk of suffering and [at Section 1(4)(f) ] the relationship that the child has with relatives ... the likelihood of those continuing ... and the ability and willingness of any of the child’s relatives ... to provide the child with a secure environment in which the child can develop and otherwise to meet the child’s needs.

13. I’ve highlighted parts of Section 1 above but in my view the whole of the Section is extremely important as a “threshold principle” but it appears to me that this is often not fully acknowledged or even sometimes not obviously known about by some practitioners.

14. There are other areas that I believe are important for the Committee to more fully explore:

15. Firstly how honest and transparent are invitations to parents by a Local Authority to request that their child be subject to Section 20 (1989 Act) accommodation?

16. Secondly the effectiveness of the Independent Reviewing Officer role in a Local Authority. My submission is that in general the carrying out of the function of that role (in particular as further required by the CYPA 2008 and the subsequent publication of the IRO hand-book) is very inadequate. I would suggest that the IRO is not and never has been truly independent of the Local Authority. The Children’s Society in verbal evidence to the committee touched on this. I would respectfully draw the committees attention to an article in “Seen and Heard” the professional journal of NAGALRO (the professional Association for Children’s Guardians, Family Court Advisers and Independent Social Workers) in the December 2011 edition entitled “IRO’s—Past, Present and Future”.

17. I would also draw the attention of the Committee to section 11 of the CYPA 2008, which gives the power to the Secretary of State to set up a body independent of the Local Authority to appoint/train/manage the work of IRO’s.

18. Thirdly I believe not enough attention has been paid to the provisions of Sec 17 of the CA 1989. Again the Children’s Society in verbal evidence touched on this. Sect 17 imposes a duty on a local authority to safeguard and promote the welfare of children within their area who are in need and ... so far as is consistent with that duty to promote the upbringing of such children by their families ... by providing a range and level of services appropriate to those children’s needs. I suggest to the committee that if it explored the range of service provided by the 150 or so different local authority’s they would find a massive variation in “attitude” to Sec 17 services. But I submit this is vital to the threshold question—in the final analysis is it acceptable for there to be a postcode lottery which effectively will decide in some cases whether a child is adopted or remains parented by their birth parent(s) with section 17 support by the Local Authority?

19. Fourthly I must refer to the “only 60 children adopted under the age of one” figure that has been quoted very widely by amongst many others the Prime Minister. As the Committee are hopefully aware the figure of 60 refers to those children under age one where the Adoption Order has actually been made by the Court (see the criteria in the SSDA903 small print). The timing of this is essentially up to the adopters (it is they not the Local Authority who apply to the Court for an Adoption Order). It would be interesting for the committee to have a view on the minimum realistic time for a proper process to occur re-assessing the birth parent(s) capacity to parent; and if negative leading on to the appropriate matching of the child with potential adopters, the subsequent placing of that child, the application by the potential adopters to the Court for an Adoption Order, and finally the actual making of the Adoption Order by the Court.

20. Finally I request that the Committee not forget Special Guardianship Orders which were introduced by the Adoption and Children Act 2002 and which came into force in 2005. Arguably the legal effect of a Special Guardianship Order is almost identical to that of an Adoption Order, with the important distinction that it does not legally “sever” the relationship of the child with his or her birth parents. For some (particularly older children) a Special Guardianship Order will be preferable to an Adoption Order.
21. If the number of children Adopted is added to those subject to Special Guardianship Orders (see the figures in SSDA903) it shows an increase of children who were moved to a permanent placement. The number subject to either Adoption or Special Guardianship Orders in 2011, increased respectively by 6% and 17% compared with 2010 and 2007. This I submit paints rather a different picture to the much quoted recent statements in the public arena (for example by Martin Narey) that because there has there has been a fall in Adoptions a radical solution is required to rectify this. I fully accept however that some unnecessary delays do occur both within the Local Authority and Court processes that need to be addressed.

April 2012

Written evidence submitted by Janine Halmshaw

1. I have witnesses and evidence to support that the following practices are taking place in the Child Protection Services department. Children are not listened to and are ignored in procedures followed by CPS and it is having a devastating effect on families. CPS use their power to take on personal vendetta’s against parents. They pick and choose procedures and manipulate them to get their preferred outcome.

2. I am happy to give evidence and speak to the committee in person but may require an advocate as I suffer from severe dyslexia.

3. CPS are not taking parents concerns seriously and are not investigating until letters from a GP express concern.

4. CPS are not investigating in a sufficient time-frame, 10 days or more in some cases. This means that any possible injuries to a child may not be present by the time a worker attends.

5. When a worker does eventually attend, more time is spent investigating the parent making the parent feel like they are the perpetrator and little time is spent listening to the child. Feedback from investigations is not fed back to the parent.

6. CPS accuses parents of having Munchausen by proxy syndrome (MBPS) with no evidence to support these claims. Even when CPS are challenged by a professional, they pursue the claim hoping to be proven right.

7. Core assessments that have been instructed immediately by the court are ignored by the CPS and can take three or more attempts of court rulings for them to eventually begin. CPS do not attend when ordered to by the court.

8. CPS instruct the court to re-instate a parents contact without a core assessment taking place or any investigations on any allegations being followed up.

9. CPS ignore court rulings to move cases out-of-area for reasons such as parties in the case previously working for the CPS in the same area or friendship with previous colleagues still working for the CPS which is a conflict of interest.

10. Inexperienced CPS workers submit reports to court based on their personal opinions with no facts or evidence included. Courts then make important rulings on these reports.

11. Reports are submitted into court on the same day as the hearings take place giving parents no time to prepare or challenge against them.

12. Parents are misled by CPS as to which professionals are assessing their child and the qualifications of the professional making the assessment.

13. Children are ignored when disclosing important information and evidence in a case.

14. CPS mislead parents that they are legally qualified to advise/threaten a parent on the best course of action to take and use their visits to gather information to use against a parent in Court.

15. CPS ignore or dispose of clear evidence of abuse and are dishonest when reporting their findings.

16. CPS are dishonest when reporting attendance of appointments with parents.

17. CPS allow information to leak out to parties involved in the case.

18. CPS ignore procedures and take children (ages five and under) out of school without having parents consent and interrogate children with no teacher present.

19. CPS pick and choose what evidence is allowed to be brought into court. Independent witnesses are accused of being in cahoots and evidence is ignored and claimed as abuse if they do not support the accusations put forward by CPS.

20. Parents are threatened and blackmailed “off the record” via telephone or face-to-face so that no proof is available for court.

21. CPS generally fail to respond to any letters or phone calls even from MP’s.
22. CPS organise child protection meetings and conferences and either do not inform all the parties involved in the case or give as little as one hours notice. Minutes of meetings are not produced to all parties and when they do arrive they are amended and any crucial evidence is removed and can’t be challenged. All parties are not notified of cancellation of meetings.

23. CPS take it upon themselves to act as psychologists and when a child is disclosing important information. The child is told that the information they are giving is not fact and then manipulate the child to suit their case in court.

24. When CPS supervise contact they manipulate their diary of events to support their case in court.

25. CPS are often late (up to two hours) or do not show up to supervise contact. If they are late they do not inform parents and then cut contact short to suit their personal lives. Locations chosen are often not appropriate for the child.

26. Independent supervisors are briefed on parents with lots of misinformation before attending and are given restrictions to impose on the parent that are beyond CPS’ remit.

27. Independent supervisors used by CPS who report anything contrary to reports made by CPS are ignored or are somehow “mislaid”.

28. If the child shows any signs of any disagreement with the actions taken by CPS, the child is taken aside and threatened/manipulated/bullied until they agree that the actions taken are in their best interests.

29. Parents are accused of not taking advice from the CPS even when the advice was never offered.

30. Other family members are ignored and threatened in any cases involving the CPS.

31. CRB checks and psychiatric reports ordered by the court are ignored.

32. Professionals base their reports based on hear-say evidence supplied in advance of doing their assessments on parents.

33. Current family courts have become “Kangaroo courts”. Interim care orders are issued on the basis of written statements from social workers and “hired experts” that cannot be questioned or disputed because these documents are not shown to the parents and in any case the authors are nearly always absent from court. The parents’ are rarely allowed to testify as not only the judge but also their own lawyers nearly always stop them from speaking. If they do manage to testify, what they say is not only disbelieved it is almost always completely ignored. The interim care orders are usually renewed automatically every month for nearly a year before a final care hearing is held, during which time the unfortunate children are isolated from their parents (except for very limited supervised contact periods) which is not in the best interests of the child.

34. CPS manipulate their own professionals/”hired experts” by fabricating evidence so that professionals side with them in the court arena.

35. Procedures are ignored when requests for CPS records are made.

36. Procedures are ignored with regards to people with disabilities. Advocates are not allowed to attend meetings or court hearings.

37. CPS spread harmful rumours and malicious gossip to schools, nurseries and health professionals with no evidence to support their claims, victimizing the parents.

38. CPS illegally obtain files and use them in court and essential files for evidence “go missing”.

39. CPS discuss important information about the case in front of the child with no thought given to the child’s welfare. When the child voices any information overheard the parent is accused of discussing the case with the child.

40. Cases drag on for four year plus, wasting tax payers money to obtain the result CPS want to achieve with no consideration for the welfare of the child and the families they are destroying.

41. CPS workers are given different positions within the organization when cases of gross misconduct are brought against them. Workers that try to help parents are dismissed.

April 2012
Written evidence submitted by Parents Against Injustice

The criteria for taking children into Care are NOT the official ones for abuse, injury and neglect, but very questionable ones as set out below.

All these are very common.

**CRITERIA FOR TAKING CHILDREN INTO CARE**

1. The family asked for help.
2. There was some technical breach of the long list of conditions surrounding an At Risk Register conference.
3. For a Medical Condition Which is Recognised as Non-Existent.
4. The family are held not to be “cooperating”.
5. The mother may have a learning difficulty, suffers from PND, have had problems with drink, self-harmed or behaviour as a teenager or been the victim of DV.

Frequently the decision to take the baby into Care is made BEFORE birth, because they have been reported by the Midwives under the Intergrated Childrens’ System.

6. An allegation is made against the family, frequently by the school or nursery, *often because of fighting or a bullying incident*, by the Named Teacher or Named School Nurse for child abuse, which then spirals out of hand.

The 1989 Children Act attempted to address these problems by building in safeguards and what is known as the Threshold Criteria, but unfortunately this appears to have been short-circuited as seen above.

**CRITERIA FOR TAKING CHILDREN INTO CARE**

One member stated to John Hemming “what evidence is there that there is widespread and endemic Forced Adoption?”

The answer is that it is endemic to the system, with the parents not allowed to prove their case they are responsible parents and the SS evidence has been manufactured, and once a decision to send the child for Forced Adoption has been made, the reports from Expert Witnesses will claim they suffer from Personality Disorders they don’t have and Guardian’s reports hostile to them so they just can’t win.

Once the decision to go for Forced Adoption has been made it is virtually impossible to stop and you get constant calls from hysterical parents trying to make appeals as Litigants in Person, as there are no funds for appeals, and the Forced Adoption being on very spurious grounds.

**For a Medical Condition Which is Recognised As Non-Existent**

The most common is our friend MSBP/FII, or as it has now been termed in the 2nd Relaunch, AIB, (Munchausen’s Syndrome by Proxy, Fabricated or Invented Illness or Abnormal Illness Behaviour).

We get a vast number of requests for help on these and THEY ARE INCREASING, and it is the most common request we get.

We now have a super-tough letter to be sent to the Director and Cabinet Member for Children’s Services or used as a draft for the initial court submission for the ICO application, which begins “Meadow and Southall the devisers of this theory have been Struck Off the Medical Register for their activities concerning this ...”.

We find we are specialising in taking down MSBP/FII applications to take children into Care on this applications at this early stage or ICO application.

Unless this happens, once the ICO has been made it will run on and on till a Final Hearing in a minimum of a year’s time and almost certainly an MSBP enthusiast appointed as the Expert Witness to give evidence.

If a firm statement is filled at this stage we find the courts demand “evidence from the alternative view be heard” or the CS Department run off.

They have been know to arrive at the house the next day to announce “we never accused you of FII...”, which of course is technically true, as it will have begun with a medic who still believes in and campaigns for this.

**Borderline Personality Disorder or BPD.**

This is the most common of the personality disorders that parents, particularly mothers, are accused of in the Family Court system. It is an accusation particularly made against women.

Unfortunately NHS psychs insist the mother does not have this condition and cannot offer therapy.
But they are not the court approved Expert Witness making this claim, so are locked out of the system by Family Court judges.

But to have such a diagnosis you must have five out of the nine Criteria on a list under the DSM—IV.

The Family Court expert witnesses do not bother about the list and we have had case after case.

Back come NHS psychs—this person cannot have a diagnosis of BPD since they do not have five of the nine criteria under the DSM—IV.

However, unless this accusation is overturned it will end in the child being made the subject of a Full Care Order and then offered for a Special Guardianship or Forced Adoption.

Again, we have many cases like this.

Borderline Personality Disorder allegations against the mother by an EW are one of the most common thresholds for sending children to Forced Adoption.

As stated above, these cannot be supported by NHS psychs who say such a diagnosis under the DSM—IV cannot be supported by the medical criteria, but are locked out of the Family Court system.

Without the court’s permission, a Second Opinion cannot be obtained from an official court appointed expert witness, which is likely to be opposed by the Guardian and LA.

The diagnoses of NHS psychs is unlikely to be regarded.

We have even had both parents accused of BPD, but the court and judge has failed to see the significance of this.

The parent is thus Emotionally Abusing the child, and may be frequently not permitted at all to see the children until they receive therapy (which the NHS say they cannot provide as the person does not suffer from that condition, or it is not available privately).

So the child cannot be returned home, so as they cannot be retained in Care, must be sent to Forced Adoption.

(4) A Psychologist Expert Witness or ISW Claim the Child is Not Attached to Their Parent

If a psychologist or ISW claim there is no Attachment by a child to its parent—there is “disorganised” attachment or “disrupted” attachment—then this will be the signal to send the child to Forced Adoption.

This is in spite of the fact there is almost certainly Attachment to the parents.

There is extreme concern about the “Attachment” theories to which the organisations Mr. Nairey is the spokesman for have taken up.

This REVERSES (repeat REVERSES) conventional Attachment Theory as laid down by Bowlby and his followers.

“Disorganised Attachment” has been invented by the Forced Adoption lobby to justify the situation where disturbed behaviour by adopted kids is discovered.

If the children are Attached to their parents, then this will occur through the breaking of that Attachment.

This is known as Reactive Attachment Disorder.

Nairey openly said in his evidence there were “myths about Attachment”, but these “myths” are in fact Bowlby’s conventional Attachment Theory.

It is claimed the disturbed behaviour comes from abuse before being taken in to Care and is Disorganised Attachment.

The symptoms for Broken Attachment with parents and “Disorganised Attachment” are the same.

The theories and arguments advanced by Mr.Nairey and those he represents are highly dangerous and are at variance with Attachment Theory.

Here are theis views on Attachment of the organisations for which he is a spokesman:-

“First, misconceptions about what is known as attachment theory—a belief that the bond with the birth mother must not be broken—often dissuade social workers from seeking to remove children until neglect is prolonged or has deteriorated into abuse. In fact, attachment theory tells us that if a neglected child is removed reasonably promptly from neglect, then that child will be able to develop a close attachment to another carer”.

Unfortunately they are not misconceptions about Attachment theory, it is Mr.Nairey and his patrons that have misconceptions about it—namely a child will be easily reattached to someone else.
This is because he is a spokesman for powerful charities and what can only be described as the Forced Adoption lobby.

The delay is because the parents oppose Forced Adoption bitterly and with all their energy to prevent their children being sent to Forced Adoption. This means a long-drawn out court case with reports from Expert Witnesses, ISW’s, Guardian’s reports, second opinions, assessment of relatives etc., and after that if a Placement Order is granted, an appeal and attempts to discharge the Placement Order. The Adoption Order then needs to be applied for after a minimum period of three months.

It is NOT, repeat NOT, true that it is a cop out to blame the courts and there is gridlock.

It is NOT, repeat NOT, true that “birth” parents are given the opportunity to demonstrate they are good carers. The actions of the CS Dept. are to justify themselves and prevent anything happening which shows they are wrong. The Expert Witnesses

It is NOT, I repeat NOT, true that the system “relaxes” when a child is taken into Care. It is simply the court case begins against the parents, which is unremitting, may go on for two years.

The hoary old one about if children are returned home they will be abused was also advanced. Serious questions would have to be asked about the research advanced, since it means no children can return home (and are therefore available for Forced Adoption).

April 2012

Written evidence submitted by Jerry Lonsdale

1. I have been a Lay Advisor for the last six years with four of those years assisting John Hemming MP with his Campaign Group Justice For Families. I have been supporting Parents, Children and Families throughout the many guises of the child protection system, whether it be attending court as an Advisor for the parents, I also assist in many instances supporting the children that the Child Protection System is enshrined to protect, I am very vocal on these issues I have a lot of experience within the child protection system, below are my personal experiences and views, over the six years I have dealt with over 200 individual cases.

2. I deal with cases whereby birth parents who feel erroneous judgments may have been made regarding their children who have or are due to be removed from their care, it is not uncommon for Foster Parents or Adoptive parents to make contact for the same.

3. During the Committee Meeting on the 13 December 2011 a question was raised aimed towards Mr John Hemming MP by Mr Craig Whittaker MP,

“Q368 Craig Whittaker: There are well over 65,000 kids in care, so your cases only represent 1.5%. We have also seen Christopher Booker get a bit of a slamming from Tim Loughton earlier on in the year, saying his campaign was “damaging, demoralising and very unhelpful”. I do not think anybody is disagreeing with you that there are some cases in the system that are clearly wrong but what evidence is there to say that actually there is widespread occurrence of forced adoption, for example?”

4. There are 65,000 children in care, Justice For Families has a case load of over 1000, the figure is not 1.5%. 65,000 children in care does not mean there are 65,000 individual cases, if a Social Worker has a case with five children, all siblings, that would be one case and not five, the figure given by Mr Craig Whittaker MP of Justice For Families of 1.5% of cases is incorrect.

5. The recently quoted figure of families having on average 1.9 children [ONS] the case figure would be around 34,210 cases [speculative], giving Justice For Families a percentage of 3%, the problem of questionable and erroneous cases is a serious one and should not be dismissed as a minority.

The impact of neglect and the long term consequences of a delay in intervention where there is evidence of neglect

6. The most difficult task one would say is identifying the impact neglect or long term consequences of delay, would have to the child’s life; while longer studies should be commissioned to understand more of the impact, the basics already known and documented cannot be taken by using a lackadaisical approach.

7. Children in care are systematically failed to be listened to by professional and authority figures, this has the most overwhelming impact on children’s lives if professionals fail to listen to the child when its most important, the child builds resistance to professionals and authority figures in the future, fundamentally the child looses any trust for Adults and professionals alike, this leaves the Child feeling isolated and vulnerable.

8. I have been given the opportunity to meet with children in care, the sad and recurring theme tends to be the children asking me to speak to the judge for them, also ask me to send the judge notes written by themselves.

9. Many Children feel written off, the voice of a child is a powerful one, a voice that should be fundamental with any decisions or recommendations this committee makes, children have the feeling of being left out, plans
10. A specific case of interest is the case of Sam and Adam from Essex, they were 16 years and 14 years, they were residing with their father, the father had an acrimonious divorce, during the court proceedings the Judge had involved the Social Services, this ultimately led to the children being placed into care.

11. Sam and Adam should have played a more crucial role in the decisions of what they wanted and more support should have been given, sadly with children at that age they constantly voted with their feet. They would flee the foster carer’s home, this had occurred on an almost weekly basis for nearly two years, the children were strong in their beliefs and what they wanted.

12. The boys would flee, the police as a matter of duty would find the boys, it was after countless police interventions, did then the police decide that it was no benefit of the boys to be removed from where they were, myself and Essex Police had found a suitable location, an agreement was reached with the police that they would not intervene again, the police were very critical of Essex Social Services for the way they were playing with the lives of the boys.

Thresholds for intervention, for taking children into care and for adoption

13. In many of the cases I have dealt with over the years the Threshold Criteria, has been spurious and somewhat over looked, when Local Authorities decide court action is the ultimate conclusion for children then a threshold document is prepared, all too common, these documents contains a plethora of mistakes and unfounded allegations, when care proceedings are initiated parents can and do oppose the granting of an Interim Care Order, unfortunately Threshold document is only DRAFT, the Local Authorities can obtain care order’s on something that has not been completed.

14. Thresholds may not be met in the early stages of the care proceedings, that does not mean the children would be returned to their parents if removed from their care, further more there is now a tendency to remove the children from parents then find the evidence to justify the actions of the Local Authorities, this is usually under the context of an expert opinion report, psychological or other, even parenting assessments are also carried out after the children have been removed from the parents, wholly and unjustly placing parents on a back foot.

15. A common point used in Threshold is lack of insight, a parent has to support and agree, the actions of the Local Authority in removing their children to be the right one, if parents disagree, the Local Authorities will use lack of insight and place parents in a position of proving otherwise which is difficult.

16. When Thresholds are made and parents are opposed, none co-operation would then be used as a point to threshold, if the Local Authority have removed the parents children for erroneous and questionable reasons the relationship is further more strained, a quote from Lord Justice Thorpe explains this in the Judgment of:-

"Mothers Hostility to social workers raises a problem which is all too familiar in the family courts. A parent whose capacity to care for his or her children in put into question is likely to resent it. Social Services on the other hand have to inquire and in some circumstances to take action, Often there will be an important question whether a measure of support the parent or parents can achieve good enough parenting, if the parent has become resentful of the social workers, whether for good cause or for bad, it will for that reason be that much more difficult to provide support. This very often leads to the parent being criticised for lack of cooperation with the social workers, and, in turn, to the parents resentment of the social workers’ intrusion growing rather than diminishing. It becomes a vicious circle. It can sometimes then be easy for social workers’ to think that an uncooperative parent is for that reason also an inadequate parent, but that one does not follow on from the other, whilst it may be regrettable, is not by itself any justification for making the care order. It is not uncommon for hostility and lack of cooperation to be confined to those who are perceived, however unfairly perceived, to be wrongly interfering in the family; and if that is the case it is quite possible to find other agencies who can establish a working relationship with the parent and provide the necessary support. To try to do this is part of the job of the social worker"

17. A specific Adoption case I would like to raise is the case of A and J in Bury, what is striking about this case is the processes that have led to the children who are aged 10 years and 7 years; the parents had the children removed from their care in 2008, they were capable parents and the concerns of the Local Authority were unfounded, the Children were then returned back to the care of their parents, an incident then occurred a few years later while innocent in nature the Local Authority had removed the children once more—[Section 33 CA 89].

18. Back before the courts, several assessments were undertaken, child psychologists, Independent Social Work, the conclusions were that A and J should not be adopted as it would not be in their best interests or welfare.

Older young people (especially those aged 15 to 19) and child protection

[Pathway] put in place to help and support the child when they reach an age when they leave care are not followed, this, I feel, a direct result of the pressures on the work loads of the social workers.
19. The Local Authority disregarded with the experts not to let the children be adopted, in 2009 the Judge agreed with the Local Authority, although highly unlikely the children will be adoptable he gave the Local Authority okay to find a placement.

20. January of this year some 2/12 years later adoption applications were applied for, what is more upsetting about this case is the early experts has forcefully suggested the children needed stability and being lost in the system would harm the children, the placement orders were granted in 2009 which placed parents in an impossible situation to overturn, the children were placed with prospective adopters in June of 2010.

21. Unfortunately the damage towards the children from being in limbo for so long may never be known however with the expert opinions being ignored its highly plausible the adoption will fail.

22. What I have written above is a snap shot of my experiences, I would have liked to expand on many of the above issues, the limitation of the submission by the committee I have been unable to expand more thoroughly, I strenuously plead with the Committee that, if possible I could give oral evidence to the committee, I have written my views and experiences it is only the tip of the iceberg, We are fully aware that the current system is deeply flawed, the committee will realise that in my submissions there are not many good practices I have mentioned, there are some though, the Children’s Act. 1989 is out dated and fails the children it was devised to protect, times move on so rapidly, that it is impossible to have Acts, Protocols and Guidance for every scenario but the Children’s act 1989 has not moved on as frequent as it should, I understand that it would take considerable effort to drag the Children’s act 1989 into the 21st Century however this Committee must make some effort to attempt to change those archaic sections of the Act that do not help Children, section 33 is a good start.

23. To make the lives of Children in care better and more successful we need to start at the grass roots of the problems.

April 2012

Written evidence submitted by Independent Investigators Mrs Jan Murray and Mrs Karen Wynne

1. EXECUTIVE SUMMARY

1.1 In the light of a recent Social Care complaint involving an Investigation of Child Abuse under Section 47 (S47) of the Children’s Action 1989 (outlined 4.1.1 below), the Select Committee might wish to consider the following:

1.2 A review of Social Care complaints investigations with particular reference to:

1.2.1 Joint Working between Social Care and the Police.

1.2.2 The accountability of both agencies working together and whether that accountability should be open to scrutiny by both of the agencies involved.

1.2.3 The transparency of Social Care complaints investigations involving more than one agency.

1.3 The universal interpretation throughout England of protocols for investigation of complaints.

2. INTRODUCTION TO SUBMITTERS, MRS JAN MURRAY AND MRS KAREN WYNE

2.1 Mrs Jan Murray and Mrs Karen Wynne are both experienced Independent Investigating Officers (IO’s) and Independent Persons (IP’s) of Stage 2 and Stage 3 of the Social Care Complaints process.

2.2 We are both experienced members of a Pool of IO’s and IP’s covering seven Local Authority areas, having been recruited under a fair and transparent recruitment process. Furthermore we are experienced Panel members at Stage 3 of the Complaints process. We have attended all training and development sessions and we are both able to undertake all roles assigned to us when requested.

2.3 We are fully independent of Local Authorities and are not qualified Social Workers. We have a wealth of experience within public sector environments; we are able to express ourselves appropriately both orally and in writing; we have shown we are able to emphasise and build working relationships with service users and local authority officers and public body employees regardless of status. We are fully aware of our responsibilities when undertaking an investigation and in compiling reports, which are clear, concise, accurate and evidenced based, so that our conclusions, findings and recommendations are sound.

3. BRIEF OVERVIEW OF INVESTIGATING OFFICERS (IO’S) AND INDEPENDENT PERSON (IP’S) ROLES

3.1 Investigations involving a child/children have to be investigated by an IO who takes the lead, and the IP who accompanies the IO, is an “advocate” for the child and is there to ensure that the investigation is carried out appropriately.
3.2 When undertaking investigations, IO and IP’s are expected to adhere to the Local Authority Social Services Complaints (England) Regulations 2006 legislation and guidance as set out in both the 1989 Children’s Act and “Getting the Best from Complaints”. Training protocols are also to be followed.

3.3 Following an investigation, reports are written by both the IO and IP, which are sent to an Adjudicating Officer, appointed by the Local Authority. The Adjudicating Officer decides whether the conclusions reached in the reports are appropriate or not and writes to the Complainant with the outcome of the Stage 2 process and it is usual at this stage to include a copies of the reports written by the IO and IP.

3.4 If the Complainant is not happy about the outcome and does not feel that the Stage 2 process was thoroughly, fairly and transparently investigated, he/she can request a Stage 3 Review Panel Hearing. Review Panels are being phased out with an increasing tendency to refer directly to the Local Government Ombudsman.

4. FACTUAL INFORMATION—WHY WE FEEL IT NECESSARY TO MAKE THIS SUBMISSION

4.1 Ref 1.2 above, Review of Social Care Complaints Investigations:

4.1.1 During a Social Care complaint investigation into a Section 47 Child Abuse investigation which involved joint working between Social Care and the Police, we concluded that a very serious “error” was made on the part of the Police who had the first contact with the family. It is important to note that we were able to conclude by linking evidence from Social Care with information given by the Police. We concluded that this error influenced the subsequent reason for and handling of the Section 47 investigation and the failure of the Local Authority to engage appropriately with the family. Our thorough investigation was able to establish facts that allegedly could not be established by the Police Investigation alone, which revealed that the family were subjected to a very stressful Section 47 Child Abuse investigation—a situation that led to a complete lack of trust in either Social Care or the Police. We concluded (and the Local Authority concurred) that the Section 47 investigation had not been necessary. However all the children are now left with both Police and Social Care records. The cause for concern is that we were barred from referring to the Police in our final reports on the grounds that the two agencies investigate their own actions and one must not comment upon the other although there is no legal reason that we can ascertain, as to why this should be the case.

4.1.2 Our investigation needed to establish the exact point at which Social Care became involved with the family and if Social Care had failed to record an important and required Strategy Discussion with the Police.

4.1.3 The Police carried out their own internal investigation. We were contracted to investigate the complaint, which involved joint working, on behalf of the Local Authority.

4.1.4 On this occasion we were able to gain the cooperation of the Police and were thus able to establish and evidence the facts (4.1.1 above) that conclusively proved a Police error but as already stated, we were barred from reporting the evidence. We were informed, by the Police that their own internal investigation had not upheld the complaint.

4.1.5 Having completed the investigated, we were later told by the Local Authority that we could not report our findings on the grounds that even when joint working, where the actions of one agency impact upon the other, each agency can only investigate their own actions.

4.1.6 Our concern is at what point does one agency’s “cooperation” in a complaint become the other agency’s “investigation”. For example, if cooperation results in “The Police were able to confirm that xxxx didn’t happen”, and has a favourable connotation, that would appear to be cooperation. If on the other hand the result is, “The Police confirmed that the xxxx didn’t happen” which has a derogatory connotation, then it would appear to be classified as “investigation”, which is not permitted.

4.1.7 Our experience has also made us aware that a Police Force can decline to respond to requests for information or in responding cooperatively, give information, upon which it is not possible to comment openly and transparently or to disclose in our reports. It must be clearly stated that in this instance there were no court orders or other similar reasons why this should be the case.

4.1.8 This has highlighted to us, both independently and together, that this is not an isolated incident. It appears to depend entirely on the individual Force as to whether they choose to engage with a Social Care complaint investigation or not. There is little point in investing in an investigation of a Social Care complaint involving joint working with the Police if the information/evidence gained cannot be reported.

4.1.9 We took the matter up with the Local Government Ombudsman’s Office and was given the following information. “The relevant guidance and regs specify what can be investigated. Clearly, where joint working is concerned it is necessary to refer to the actions of other agencies in a factual manner eg the health visitor/police made a referral to Children’s Services but I would not consider it appropriate for an IO/IP investigating a complaint about Children’s Services to comment on the actions of other agencies. This is because those agencies have their own complaints procedures.” She went on to state, “It is for the police to consider any complaint about its actions and if the complainant remains unhappy s/he can ask the IPCC to
consider it.” In giving this personal opinion, it needs to be noted that a complainant would need grounds for so doing and without knowledge of the evidence it would be impossible.

4.1.10 Joint working between the Police and Social Care should be open to thorough and transparent scrutiny—each agency to be accountable to the other and to the public, (where appropriate). It is our belief that were this to be the case, the current protocols, to which Social Care and the Police should adhere, to ensure good practice, would be more effective and of course, have cost benefit in the reduction of complaints.

4.1.11 IO’s and IP’s can recommend that a particular complaint is referred to the Local Safeguarding Children’s Board which can address issues of joint working. Again, this is of little use if IO’s and IP’s investigating Social Care complaints cannot report adverse findings concerning joint working.

4.2 Ref 1.2 The universal interpretation throughout England of protocols for investigation of complaints:

4.2.1 “Getting the Best from Complaints—Social Care Complaints and Representations for Children, Young People and Others” provides guidance on the process of Social Care investigations. However, in the words of one Complaints Officer, “It is open to loose interpretation by each Local Authority”.

4.2.2 This guide does not give clear unequivocal guidance to Complaints Officers, Complainants, IOs and IPs on “Joint Working between agencies” and leaves scope for erroneous incidents to pass unrecorded and uncorrected.

5. Recommendations for Action

5.1 The instigation of a review of Social Services complaints investigations where there is joint working between the two agencies involved in Child Protection investigations. This to focus on:

5.1.1 The possibility of fully independent joint investigations (not former Social workers or former Police personnel).

5.1.2 Who funds and manages such investigations.

5.2. A complaints procedure, which has the children at the heart of the process.

5.3. A review and strengthening of principles and protocols recommended in “Getting the Best from Complaints—Social Care Complaints and Representations for Children, Young People and Others” to ensure clearer, stronger and most importantly, universal interpretation.

April 2012

Supplementary written evidence from Florence Bellone

THRESHOLDS FOR INTERVENTION, FOR TAKING CHILDREN INTO CARE AND FOR ADOPTION

INTRODUCTION

In a Daily Telegraph article, the 23/12/11, we could read:

“At 490, the county has the third highest number of ‘looked after’ children in the South West of England”.

Councillor McLain said: “I suppose it’s because our thresholds are quite low, so if we think there’s any risk to a child our first instinct is ‘let’s get them safe’.”

This cannot describe best the nature of the threshold. It lies in “If we think” and in this case, it results in “quite low”. The threshold is no evidence but opinion. It leads to a flexible standard for deciding of what Martin Narey himself, front of the Education Committee, called a death sentence. Opinion is subjective. Psychiatry and psychology are not exact sciences. When used to support the threshold, psychiatry and psychology loose their medical ambition and become a police tool. Thresholds are never submitted to public and media scrutiny. They are secret and parents cannot submit their own to anybody but a confidential team that they didn’t choose. Why such a lack of transparency when it comes to interventions which can affect every family? I have interviewed several children who have spent some time under threat of being taken away from their families. They are all but naive regarding the arbitrary manners of social services. Two siblings under gagging order, 11 and 13, told me how they just wait for telling the world how social services destroyed their lives and family. Even well aware of their own cases, no one really understood the word “threshold”. They said “false allegations”.

1. The threshold, an Inquisition value

When it comes to pregnant women and their babies shamefully named on social services reports “Unborn Smith, Unborn Taylor or whatever” the threshold is built by naming evidence the future. I have seen written: “the evidence shows that she is a certainty to cause emotional harm to her son in the future”. This makes pregnant women, especially the ones who are socially disadvantaged, heretics. The threshold is designed to
implement a preventive punishment in order to avoid the crime to be committed. The immorality of this cannot serve a balanced society but rather institutionalize the brutality of our society. As for the Migrant Children program, it can last long enough to built several generations of people bearing the burden of a state decided destiny. I have also interviewed adults who have been forcibly adopted. This never left them and some could even not remember why their adoption was not working, as they were too young. The haunting thing was all about the first separation.

2. The abuse of power for obtaining a threshold

Devious historical situations like Vichy government in France taught us that all sort of staff and professionals, with education or not, might become zealously devoted to the power of ruining the lives of their kind. Do they by cowardice or unsuspected darkness? The fact is that they do and the fact is that the state is using their fear and negative desire as well for getting what it wants. What do you think is happening when social workers look for a threshold? To refuse to consider the dark side of the humanity when it comes to social workers would be at least naive. They are in charge of speculating on the dark side of the parents and do it mostly by exercising their own. Several parents quoted me the sudden disappearance of a sensitive and human social worker from their case after he or she wrote a report in favor of keeping the family together. One social worker who had just left his job wrote to me that “he was fed up with taking away children for no reasons”. He later came back to social work, I don’t know if because short of money and job or for other reason. In the whole police of the families, from school to hospital, sometimes from neighbors to jealous partners, you can also observe the witch hunting spirit at work.

Finally the threshold can barely be challenged in Court, I would say almost never when it is about new born babies. The demonstration of an unfair or wrongly done threshold is often answered by “(but) this is in the best interest of the child to be adopted”. There is “some killing in the name of God” in the relationship between threshold and this “best” interest.

3. One County where even first time pregnant mothers reach the threshold by neglecting their child

The county which is my most regular field of investigation claimed in may 2011 having 780 children in care and a serious shortage of foster carers. When I met “my first mom” there, I knew about 10 others after a month. Yet each one has several friends or neighbors being in the same dreadful situation. When walking in this estate with one of them, we cross others. They enquire on those who have not been seen from their last child protection conference. We also spot frequently social workers on their way to make an assessment. Social workers gather the many hazards of the life of the humblest and make them hard material. They show a particular appetite for everything bad which happened in the childhood of the parents. No therapy is good enough to prevent a victim of being blacklisted on the so-called child protection register. The word “neglect” is the adoption “code” as they don’t dare writing neglect in-utero!

4. Ana—Julie

There is—I weight my words—a big deal of sickness in the way many social workers grill the parents. They play cat and mouse and seem delighted by their progresses in cornering a mom. When Ana asked several times when she would know about her fate, the social worker could never answer. This is probably due to the many families having escaped abroad. When this happen, social workers could think that the burden is now for their foreign counterparts but they don’t and here is a proof of how they are then very far of a real child protection concern: Julie managed to give birth in another country where local social services helped her to sort out herself, despite the difficulties everywhere in term of public funds. The social workers in her home town finally learned of her situation by the police and of the fact that she was receiving social support. Four months after the birth of her baby, they were still sending threatening letters to the family and asking for the lady’s return with her baby to attend a child protection conference! The mom had left legally and voluntarily. The problem of the LA was now its failure to get her, not its failure to protect a child.

5. Jane

Jane had lost her first baby to adoption because social services refused her four years partnership with the father. He was a bad boy during his youth but repented, honestly living and with good report from the probation officer. The social services hit back for Jane second baby. Her partner was this time nowhere to be seen, having opted for saving the chances of Jane’s motherhood. The social worker started her threshold on the fact that Jane won’t be able anyway to have a non violent partner because she had been a victim of violence herself into care. Jane had effectively one violent partner when becoming an adult and she eventually dumped him. Her following partner that she would describe as the sweetest man even is the one that social services didn’t want to be a father.

6. Lara

Lara had difficult teen years hanging around with boys, and pint of beers making her angry. She was convicted for disturbance of the peace and was given courses of anger management. She has no history of drugs or dishonesty but she got pregnant at 15 and lost the custody of her child to the father who is much
older than her. She has however a very good relationship with her daughter. The support and love of her own mother has been paramount in her recovery from depression and drinking. At 25 she became pregnant again and asked the social services if she could keep her baby otherwise she would rather opt for a termination. She was fully reassured on this but a couple of weeks before giving birth, they came back to her with other intentions. She spent four months with her baby to a residential unit. I have a collection of witnessing by mothers and couples who have been interned in those units and draw the same conclusion: everything is done to break you as a human being, as a partner, as a parent. There, Lara was however reassured by the social worker that she would “pass” and keep her baby. But the day before her departure, she was dragged to court and her baby taken for adoption on the base of learning difficulties and borderline personality disorder. (What I see in Lara is rather no education and a package of traumas.) The psychologist said in Court that a year therapy, even nine months, would make her OK. But a social worker informed the family that the therapy was not available in the NHS, too expensive in private and that “the adoption panel would not accept to wait for it anyway”. This conflict of interest is just one of many aberrations on Lara’s case. It was several months of struggle to obtain that she would receive her order and judgment, two pages on which is written: “the threshold criteria for making a care or a supervision order was met” and also that this threshold “was agreed by the parties”. This was signed by Lara’s solicitor but Lara never agreed on it. More than half the document is about the father thought he didn’t really seek custody but wanted to save the child from adoption. From Lara, it is said: “We see that mother loves her child and would dearly like to be able to parent him”. Which help did she get for it? And: “Because mother is so desperate to parent her child, she has been less than honest on many occasions and giving evidence to the Court”. Who would be honest with an administration trying to take away your new born baby? And finally: “the child has not suffered any harm because of the preventative action of the LA”! Knowing every page of the case and the whole family for one year, I can’t believe that the social workers themselves believe it. In one of Lara’s attempts to have permission for appeal, the LA solicitor pleaded “the human rights of the future adoptive parents” who had even not met Lara’s child. This new trend is supported by the pro-adoption campaign which diabolizes “birth parents ruining the lives of the adoptive parents when looking for their children”? In the COA, a judge refusing a permission of appeal, said: “the baby has moved on with his life and the adoptive parents to be would be devastated”! The case was involving a young middle class couple accused of hitting a baby actually suffering bones problems (a classic in child protection history). The judge didn’t want an expensive medical countercheck asked by the solicitor to review the dashed off enquiry.

CONCLUSION

Last autumn, Lara’s 16 years old sister was stabbed by an 18 years old man whom knife came to 1 mm of her windpipe. It took the police 10 minutes to arrest him thanks to several witnesses. Because they couldn’t agree on if it was an accident or an attempt of stealing her mobile phone... the police decided to not prosecute him. This is a lesson of moral for Lara and her family. No evidence good enough for punishing a serious crime, no evidence needed for keeping a woman of being a mother.

Written evidence submitted by Jane Held

RE: EVIDENCE TO EDUCATION COMMITTEE 7 MARCH—SUPPLEMENTARY WRITTEN EVIDENCE

Further to the evidence I gave orally to the Committee on the 7 March 2012 I have set out as requested supplementary written evidence to expand on the issues we discussed.

I have clarified the figures on referrals to both Birmingham and Leeds. The figures reflect both contacts and referrals.

Birmingham receives between 7,000 and 8,000 contacts per month. It receives between 1,700 and 2,000 referrals per month. On current performance the estimated number of contacts in 2011–12 will be 35,500. The estimated number of referrals in 2011–12 based on current performance is 21,200.

Leeds receives between 2,000 and 3,000 contacts a month and between 1,000 and 1,500 referrals a month. On current performance Leeds estimates that the total number of referrals in 2011–12 will be 13,500.

We have set up a sub-group in Leeds to focus on the work being done “at the front door” but it has not yet produced its first quarterly report as the new approach to referrals and contacts begins in April 2012.

We do not as yet dip sample and track cases from contact to final outcome so regrettably cannot give you data on outcomes at present. This is work that is being developed in both areas but is not yet in operation.

I also attach the Annual Report for Leeds, and the Performance Framework for Leeds. Birmingham has not yet done an Annual Report and will not publish its first until July 2012. However Birmingham does have a detailed performance bulletin which can be provided if requested.

April 2012
Written evidence submitted by Professor Judith Masson, School of Law, University of Bristol

1. I am an academic lawyer, specialising in child law and empirical research. With colleagues, I have conducted a series of studies into the operation of part of the child protection system, specifically:
   - the use of emergency powers to protect children separate studies of the use of Police Protection (Children Act 1989, section 46) and Emergency Protection Orders, published together as Masson et al (2007), Protection Powers, Wiley;
   - care proceedings (three studies between 2006 and 2012) (1) The Care Profiling Study MoJ Research Report 4/08 an analysis of 386 sets of care proceedings in England using court files selected from eight different areas of the country. (2) Pearce, Masson and Bader, (2011) Just Following Instructions? The representation of parents in care proceedings. An ESRC observation based study of the representation and court practice in care proceedings. (3) Families on the edge of care included the analysis of a sample of 173 sets of care proceedings (see below); and
   - the use of the pre-proceedings process introduced in 2008. ESRC funded Study Families on the Edge of Care Proceedings (RES 062–23–2226) on the use of the pre-proceedings process through analysis of local authority records, interviews with professionals, observations of pre-proceedings meetings and interviews with parents who took part in pre-proceedings meetings (see paras 5—(below).

2. This research relates to the statutory and court processes—it therefore focuses on the children/families that are most deeply involved in child protection processes, not those who are considered for child protection plans or subject to them for only a short time before difficulties are resolved.
   (I) There is a mismatch between many media portrayals of child protection practice (and some of the written evidence submitted to the Committee) and the research evidence of its operation in practice. Specifically, research does not support the view that local authorities bring proceedings without good reason.
   (II) There are few cases brought to the courts where the family is not already known to children’s social care. The majority of cases involved neglect and are associated with parental substance abuse, mental health difficulties and/or learning difficulties, and where families there are poor relationships between the parents. In the Care Profiling Study over 70% of cases involved domestic violence and almost half drug or alcohol abuse.
   (III) Where cases result in care proceedings, local authorities have often been trying to engage families for a considerable time before the application was made. The average length of time for cases where the local authority had used the pre-proceedings process to work with parents before bringing care proceedings was 19 weeks. In addition, more than a quarter of these cases had been subject to a child protection plan for at least three months before the pre-proceedings process was started.

Thresholds

3. The term threshold is used in a number of different ways:
   (I) For lawyers it means that the standard set for obtaining a care or supervision order in section 31 (or in other provisions) is met AND can be proved.
   (II) Other people may refer to it solely in terms of harm justifying further action without reference to what that action is or whether there is proof of the harm.
   (III) The threshold for entering the child protection process—calling an initial child protection conference is different from that for proceedings because the purpose is different. The conference is intended to provide a means of exchanging information and reaching an interagency agreement about concern, not for a case to curtail or supervise the exercise of parental responsibility.

4. Thresholds for court proceedings cannot be seen solely in terms of the seriousness of the harm to a child. Local authorities do not bring proceedings where alternative protective arrangements can be relied on. The resources care proceedings require, including court fees close to £5,000 mean that local authorities scrutinize the need to bring proceedings carefully. A lack of parental co-operation indicated by a failure to be honest in dealings with Children’s Services or to comply with a written agreement made with Children’s Services is likely to result in the escalation of concerns because children remain vulnerable where protective arrangements are not adhered to.

The Pre-Proceedings Process for Care Proceedings

5. The introduction in April of a pre-proceedings process (Children Act 1989, Guidance and Regulations, Vol 1, paragraphs 3.25–3.33) was intended to ensure cases were better prepared, parents had access to legal advice before proceedings were started, some proceedings were avoided, and those that could not could be dealt with more expeditiously. Local authorities were expected to use the process unless there was insufficient time to do so—ie immediate action was required. The process involves sending a letter to parents (a letter...
before proceedings) raising the local authority’s concerns and inviting them to a meeting (a pre-proceedings meeting) to discuss these. The letter qualifies parents for level 2 legal advice so they can have a legal representative present at the meeting. Lawyers receive a fixed fee of £365 for providing legal advice at representation in the pre-proceedings process.

6. Research conducted by Bristol University and University of East Anglia (see paragraph 1 above) shows considerable variation in the use of the pre-proceedings process, both in the ways it is used and the frequency of use in different local authorities. In part, this reflects social workers and managers getting to grips with a new process, which was not based on research evidence or a consultative process, and it part the different demands of cases/clients and styles of social work practice. However, detailed study in six local authorities in England and Wales shows that these authorities have sought to make the process effective to engage families with a view to avoiding care proceedings, to ensure that the local authority has more information about the need for proceedings before the application is made, and/or to plan arrangements with parents for the child’s care and court hearings at the start of proceedings.

7. The pre-proceedings process is particularly used to ensure that parents have legal advice during pre-birth assessments where local authorities have the level of concerns that a child will be at risk of significant harm from birth. These cases frequently involve families where children have previously been subject to care orders because of abuse and neglect. Other factors include substance abusing mothers, mothers with serious mental health difficulties or learning difficulties. It is not possible to bring proceedings before birth (nor should it be).

8. The majority of cases where the pre-proceedings process is used involve children who are on child protection plans. There are substantial differences between these two processes (1) the pre-proceedings process is internal to the local authority, involves a small meeting (average around seven people) and legal advice/assistance for the parent and (2) Initial child protection case conferences are large interagency events for sharing of knowledge about the family and the creation of a plan accepted by all agencies who work with a family. Parents are not entitled to legal representation, there is no encouragement for them to bring a lawyers and the level of legal aid payment for such attendance effectively prevents most parents obtaining legal advice. There was apparently no consideration of how the pre-proceedings process would fit with child protection conferencing when the pre-proceedings process was introduced. This is a symptom of the lack of consultation in the introduction of the process.

9. A proportion of cases (around 25% where the pre-proceedings process has been used) have not progressed to care proceedings within six months but it is not possible say in most cases that, without the process, care proceedings would have followed or that diversion from care proceedings will be permanent. However, most professionals interviewed for the study favour this method of working with families at high risk of care proceedings. Parents too who have participated in a pre-proceedings meeting with their legal representative present are positive about the process. They felt supported by having a representative present.

10. For cases where the process was used but care proceedings followed, there is evidence that using the process risks potential delay for children. The average length of the pre-proceedings process (excluding cases where it was only used to notify parents of proceedings) was 19 weeks. This was not reflected in a corresponding speeding up of proceedings for cases that went to court. There was no statistically significant difference in the duration of care proceedings where the process was and was not used. Local authority lawyers, social workers and managers reported that the courts took no account of what had occurred during the pre-proceedings process and usually ordered further assessments. This was confirmed by interviews with parents’ solicitors and an analysis of the court files.

11. Data collected by the Legal Services Commission shows that around 6,200 legal aid bills for this work in 2009–10 and 2010–11, and around 5,800 bills in 11–12. This decline reflects views that there is little point local authorities doing additional work before proceedings if this has no impact on proceedings. It also highlights the interrelated nature of local authority and court processes in cases at the ‘heavy end’ of child protection.

12. Of the care proceedings brought by the six local authorities in the Families on the Edge of Care Study only 12% were completed within the six months time limit that has subsequently been proposed by the Family Justice Review. These were care applications brought in 2009–10. This indicates the very considerable changes that are required for the successful implementation of the proposed clauses in the Children and Families Bill to be introduced in 2013.

13. Judicial interpretation of the Children Act 1989 appears to have made it more difficult for local authorities to obtain interim care orders at the start of proceedings. This change occurred in the mid 2000s through judicial interpretation rather than statutory reform. The Children Act 1989 does not set a separate standard for removal of children under interim care orders, nor different tests for interim care and interim supervision orders. On the one hand, this means that decisions of the courts about the need to separate parent and child are not prejudiced through an interim order but left until for a final hearing. On the other, it means that children who have been neglected and are eventually made subject to orders experience an additional period of neglect/poor care and, in some cases, emergency removal. The length of proceedings, on average over 12 months can mean a very substantial period (as a proportion of the child’s life) in detrimental conditions. It can also mean that planned arrangements for children’s care made before proceedings are instituted by the local authority are
replaced by emergency arrangements when poor care results in a crisis necessitating removal of children before the final hearing is reached.

14. Effective child protection for the most serious cases requires better collaboration between central and local governments and between various central government departments. The pre-proceedings process provides an example of an idea that was inadequately developed before implementation, monitoring of which was left to the interest of academics rather than built in, and which has had more limited impact because of the response of the courts.

May 2012

Written evidence submitted by Action for Children

EXECUTIVE SUMMARY

— Childhood neglect is a major feature of life in the UK. The proportion of children who experience neglect remains at an unacceptably high level. It is unacceptable first and foremost because neglect ruins the lives and potential of children, but also because it is within our power to do something about it.

— Action for Children, working in partnership with the University of Stirling, is finalising a review of responses to child neglect across the UK (the research will be launched late January 2012). The initial research findings form the basis for this submission and show that while there have been positive changes in public awareness and some pockets of good local practice have developed, there is a long way to go before we can expect a significant improvement for neglected children.

— Systems in place across the UK to assess, monitor and record the needs of local children do not work sufficiently for the issue of child neglect. Without changes to the ways in which individual, area and national data are collected we cannot hope to provide the strategic and comprehensive responses required, or indeed to know that local practice is making a difference.

— The public need clarity about what constitutes neglect, both to support their own parenting and inform them if they are concerned about others. Too often parents are unaware of the support services that are available in their area.

— Local child protection and safeguarding systems have been shown to stand in the way of appropriate assessments for neglected children, and can act as a barrier to effective early help. This must be urgently addressed. At the same time we need a rebalance in local-community based provision to provide early help as well as crisis responses.

ACTION FOR CHILDREN

1 Action for Children is committed to helping the most vulnerable children and young people in the UK break through injustice, deprivation and inequality, so they can achieve their full potential.

2 Action for Children helps nearly 200,000 children, young people and their families through nearly 480 projects across the UK. We meet the needs of children and young people who most need support to achieve their full potential. Through our work and through speaking out, challenge injustice and empower children to overcome the obstacles in their lives that hold them back.

3 The safeguarding of children and young people is central to everything Action for Children does.

4 In the new year Action for Children will launch the findings of our first annual review of child neglect, undertaken in partnership with the University of Stirling.380 This review enables us to fill in some of the gaps that currently exist about the situation for, and response to, neglected children; looking at how good are we at recognising children who are at risk of, or who are experiencing neglect? And, how well are we helping children at risk of, or currently experiencing neglect? The review takes a broad definition of neglect and includes early signs and concerns around neglect, not just responses to confirmed child protection cases.

5 While the initial findings from the review of child neglect forms the basis of this submission, Action for Children also provides support services for children who have been sexually abused. An evaluation by Canterbury Christ Church University has demonstrated the effectiveness of our therapeutic services in reducing the display of sexualised behaviour, self harming behaviour, reducing the numbers of children displaying violent or aggressive behaviour, experiencing sleep problems or having nightmares. The researchers also found fewer emotional problems following intervention. Action for Children is concerned that vital and effective services such as these increasingly falling victim to public expenditure cuts. If called to give oral evidence we would be happy to also address this point.

380 2062 adults in the general public responded to an online poll and a total of 2174 professionals responded to an online poll (1177 primary school staff, 140 pre-school/nursery staff and 329 health professionals). 282 social workers and 246 police officers also gave their views. We also conducted interviews with 47 local authorities (boards in Northern Ireland) and partnerships, and, undertook in-depth focus groups in six areas
Question 1: Whether the child protection system allows for effective identification of, and early help to, children at risk of different forms of abuse and exploitation (including, but not restricted to: neglect, sexual and physical abuse, domestic violence, forced marriage, female genital mutilation, child trafficking and online exploitation)

6 Child neglect is the most pervasive form of child abuse in the UK today. It robs children of the childhood they deserve and leaves broken families, dashed aspirations and misery in its wake. And, while we know more about the causes and consequences of neglect than ever before, it remains the biggest reason for a child to need protection. Too many children are still experiencing chronic neglect throughout large parts of their childhood and are not getting the help they need when they need it.

Identification

7 Neglect is the most common category for children being made subject to a child protection plan, but our research shows that neither local authorities nor national governments know how many children are experiencing neglect. Many do not collect data about the prevalence of neglect, other than that required on children subject to child protection plans. The research also shows that local areas all collect data in different ways and that there are concerns about accuracy.

8 Even if completely accurate, the reported statistics under-estimate the reality of children’s experience because many neglected children do not end up on official “lists”. Studies suggest that up to 10% of all children experience neglect.

9 There is clearly a need for more consistency of statistical reporting methods across the UK, not least so that services can be planned to best address the needs of children. Unless we have proper information about the number of children who are experiencing neglect (locally and nationally) it will be impossible to plan effective services to meet the needs of children.

10 A new, more accurate model is required that includes numbers of children coming to the attention of all agencies, including adult-focused services. Information about local needs is the bedrock of effective commissioning, and without a specific focus on the identification and recording of local data we cannot hope to know that local services are making a difference.

11 Just as it is important to collect better data about the scale of neglect, it is also important to dedicate far more attention and resource to ensuring that the services we do offer are effective and meet children and families’ needs. Although there are many local attempts to develop better approaches to outcome measurement, there needs to be a far more integrated and overarching approach if we are to ensure that our, now increasingly scarce resources, are not being wasted.

Early help

12 Encouragingly, most practitioners appear to have heard the message that it is important to identify neglected children at both an early age and at an early stage of difficulties developing. What appears less clear is how many children receive direct help as a result of these concerns and discussions.

13 Within our review we ran in-depth focus groups with professionals. Professionals stated that they recognised that there are still large numbers of children experiencing what may be considered to be “borderline” neglect and who fall below the perceived criteria for action. It is not always clear to professionals when there is enough evidence to act nor do they appear clear at what point the “drip-drip” effect of neglect is having a serious impact on the child. It was suggested that social care agencies are so inundated with referrals that the children who need help the most are not identified as quickly as they should be.

14 We need commitment to long-term effective early intervention services measured by outcomes not outputs. What would stop children being neglected is: access to personal support services in the long term, intensive support services for those in greatest need now and a move towards transforming service provision so that we have more low cost high volume early intervention services and fewer high cost, low volume services for those in acute need.

Question 2: Factors affecting the quality of decision-making in referral and assessment, and variations across the country

15 Systems on their own do not protect children—people do that. Children need a system that promotes and supports effective decision making. To achieve this will require investment in the training, supervision and management of those staff who work to protect the most vulnerable children and young people.

16 Once a child is identified as neglected or at risk of being neglected, and their plight brought to the attention of our helping systems, appropriate help should be offered immediately, but it is surprisingly difficult to find out how well this is happening. There are large numbers of children about whom a range of people may be concerned and who are known to communities and professionals but who are not actually receiving adequate direct help. For example, some services operate a system whereby missed appointments can lead to families returning to the end of waiting lists. This has potentially serious consequences for work with children in these families. Child neglect is associated with families who often have very chaotic lives and suffer severe
economic and emotional pressures. Parents in these kinds of situations have the most to gain from specialist support, but are the most likely to miss appointments, especially if no relationship has been established with a practitioner.

17 There is a tendency for some children and families to “bounce” in and out of services. Services are in place for a short time and then withdrawn when the urgency recedes. The clear research evidence of the need for longer term support appears not to have filtered through to service planning or provision.

Question 3: Appropriate thresholds for intervention, including arguments for and against removing children from their families

18 The wish of professionals in universal roles to be able to report concerns earlier supports the perception that there is a “thresholds” system operating whereby the child’s circumstances have to be viewed as very high risk before action will be taken.

19 Neglected children suffer from the influence of a forensic investigative system which still has a powerful filtering effect and influences judgements about the severity of likely harm and need for action. This system, as embedded in the Children Act 1989, typically involves swift investigative processes that are designed to look for “hard” evidence of abuse. This is not helpful in cases of neglect.

20 Neglect is often unpredictable and cumulative. It involves harm of an emotional nature and where the nature of the harm is in itself to do with parenting being erratic. These kinds of situation call for careful assessment and analysis that is not necessarily encapsulated within “investigation”. Neglected children would benefit from a system that recognises that timescales will vary for different children. This is not say that children should be allowed to suffer over long periods of time, but it is important that all the key professionals have the space and time to undertake a full and proper assessment that includes analysing and forming and testing hypotheses and conclusions. This system would explicitly see practitioners expected not to conduct business rapidly for the sake of it but purposefully and with a focus on the child’s outcomes. This system would also see there being available the tools and time to practice and reflect. Much of this has been recommended by Munro (2011b) for maltreatment more widely, but for neglect specifically it is key that these recommendations are put into action.

Question 4: Whether the child protection policies and practices of non-social work agencies and Government departments assist professionals to work together in the interests of the child

21 As outlined in the paragraph above, the child protection system we have developed struggles to provide an effective and swift response to neglected children. Legislation, policy and guidance have developed with good intentions, but a distance has developed between common-sense empathy with the unhappiness of hungry, tired, un-kempt and distressed children and an overly bureaucratic and anxiety-ridden system for reaching out to help them.

22 Communication between agencies appears to be improving in most areas, aided by developing multi-agency groupings. However, there are still barriers in partnership working which have an impact on identification. Information sharing between some agencies is not always good enough, with lack of clarity about data protection regulations still in evidence in some areas. Even when protocols are in place there can be problems at ground level, especially in the early stages when neglect is suspected rather than once it has been substantiated.

23 Current problems are being exacerbated by the lack of specialist treatment services for parents facing difficulties in their own lives. There is a gap in services for adults affected by substance misuse, mental health problems and domestic abuse. Given that these factors are so often associated with neglect it is perverse not to provide adequate and effective specialist help to eliminate them.

24 Finally, our initial findings show that, where funding cuts to services have not yet happened, the fear of cuts on cuts in the future is very real. Local areas are worried that important new developments, such as putting in place services aimed at intervening earlier and offering support before problems get worse, will be stalled. Encouraging agencies to work more closely together to avoid “referral on” requires staff from services to have time to attend meetings, talk to one another and plan supports for individual families carefully. This collaboration needs to be on-going and cannot be achieved if services are stretched and trying to do more for less. It is vital that such developments are resourced to continue. Budget cuts to services for children and families are a false economy.

Annual Review of Child Neglect 2011–12

25 In conducting the annual review the University of Stirling and Action for Children undertook a telephone survey in 34 local authorities and via email in a further 11.381 We also ran in-depth, on-site focus groups in six areas across the UK.382 2062 adults in the general public383 and a total of 2,174 professionals responded

381 The survey asked about the ways in which children with unmet needs could come to the attention of someone in a position to help and the nature and funding security of the services for children and their families

382 Focus group participants included practitioners from children’s services, health service staff, Local Safeguarding Children’s Board members, third sector, police, housing and education.

383 YouGov panel, fieldwork 3—22 June 2011, figures weighted and representative of all UK adults (aged 18+)
to an online poll (1,177 primary school staff, 140 pre-school—nursery staff and 329 health professionals). 282 social workers and 246 police officers also gave their views.384

26 The final report will tell us:

— If the government or local authorities know how many children are currently experiencing neglect.
— How good we are at recognising children who are at risk of neglect.
— Whether the public feel confident to report concerns about a child (and if not why not).
— How well we are helping children at risk of, or currently experiencing neglect.
— If professionals feel empowered to take action, and if not why not.
— An outline of promising developments.
— We will also make recommendations about exactly what can be done differently to help neglected children.

April 2012

Further written evidence submitted by Action for Children

EXECUTIVE SUMMARY

— The proportion of children who experience neglect in the UK remains at an unacceptably high level with studies suggesting that up to 10% of children in the UK experience neglect at some point in their lives.
— Action for Children, working in partnership with the University of Stirling, has conducted a comprehensive review of responses to child neglect across the UK. “Child neglect in 2011”, enables us to fill in the gaps that currently exist about the situation for, and response to, child neglect. Key findings include:
— Neither government nor local authorities know exactly how many children are being neglected.
— Over half (51%) of social workers, and a third of police officers (36%) report feeling “powerless” to intervene in suspected cases of child neglect. For social workers this figure has risen from just over a third since 2009.
— Social workers gave the main barriers to intervention as: the point at which they could intervene in cases of child neglect was too high (42%), and, the child’s need met the threshold but there were “insufficient services” (43%) or “insufficient resources” (52%). 80% of social workers think that cuts to services will make it more difficult to intervene in cases of child neglect.
— 52% of members of the public polled said they have been worried about the welfare or safety of a child they know or who is living in their area. This figure has increased by 8% since 2009.
— 37% of members of the public polled said they would like more information about who to contact if they have a concern about a child who is being neglected. This has gone up from 23% in 2009.

ACTION FOR CHILDREN

1 Action for Children is committed to helping the most vulnerable children and young people in the UK break through injustice, deprivation and inequality, so they can achieve their full potential. We help nearly 200,000 children, young people and their families through nearly 480 projects across the UK.

2 Action for Children has launched our first annual review of child neglect, undertaken in partnership with the University of Stirling. In conducting the review we undertook a telephone survey in 34 local authorities and via email in a further 11.385 We also ran in-depth, on-site focus groups in six areas across the UK.386 2062 adults in the general public387 and a total of 2,174 professionals responded to online polls (1,177 primary school staff, 140 pre-school—nursery staff and 329 health professionals). 282 social workers and 246 police officers also gave their views.388 We took a broad definition of neglect which includes early signs and concerns around neglect, not just responses to confirmed child protection cases.

3 Action for Children provides a range of services to overcome neglect. Through our services and our research we know that working with families at an early stage has significant impacts avoiding problems becoming entrenched and irreversible. We are committed to increasing knowledge about what works in addressing child neglect and are currently undertaking a four year study of our neglect intervention projects as well as developing new services to provide relationship-based support for vulnerable families.

384 Through the YouGov panel, with fieldwork 13—21 June 2011
385 The survey asked about the ways in which children with unmet needs could come to the attention of someone in a position to help and the nature and funding security of the services for children and their families
386 Focus group participants included practitioners from children’s services, health service staff, Local Safeguarding Children’s Board members, third sector, police, housing and education.
387 YouGov panel, fieldwork 3—22 June 2011, figures weighted and representative of all UK adults (aged 18+)
388 Through the YouGov panel, with fieldwork 13—21 June 2011
The impact of neglect and the long term consequences of a delay in intervention where there is evidence of neglect

Impact of neglect

4 Neglect is far reaching in its consequences. Not only will the experience of it make a child’s life miserable, it can affect all aspects of their development and influence the relationships they make throughout their lives. In the most extreme cases, neglect can lead to the death of a child or be one of the causes of non-accidental death. The analysis of Serious Case Reviews (2003–5) found that neglect features in a third of cases where children die or are seriously injured.

5 Neglect can have effects across the lifespan, including:

- Health and physical: early brain development including in ways which influence how a child reacts to stress; emotive development and language delay and physical injuries.
- Emotional effects: insecure attachment problems; low self-esteem, over-compliance or hostility; anxiety and depression.
- Social effects: social isolation; social exclusion including anti-social behaviour; poor school attendance and attainment.
- Adolescence and adulthood: becoming involved in risky behaviours; self-harm and suicide attempts; difficulties in forming relationships.

Childhood neglect is a major feature of life in the UK today

6 The proportion of children who experience neglect in the UK remains at an unacceptably high level with studies suggesting that up to 10% of children in the UK experience neglect at some point in their lives.

7 Despite this, our research shows that neither local authorities nor national governments know how many children are currently experiencing neglect. Of the 47 local areas we surveyed, only 21% collect data about the prevalence of neglect other than required data on child protection plans. And of these 21 areas, most only reported on official child protection figures rather than from other sources. Yet we know that the reported statistics dramatically under-estimate the reality of children’s experience.

8 Unless we have proper information about the number of children who are experiencing neglect (locally and nationally) it is impossible to plan effective services to meet the needs of children. The Government must help local areas improve data collection about the scale of neglect and effectiveness of services. In the first instance we recommend that:

- The DfE must revise the Children in Need census to improve local authority data collection about child neglect.
- The Department of Health must update the Joint Strategic Needs Assessment framework to include numbers of Children in Need in the core data set.
- The DfE must amend the Working Together statutory guidance to give professionals more space and time for full and proper assessments to tackle chronic neglect.

The public are increasingly worried about neglect but do not always report it

9 52% of the members of the public we polled said they have worried about the welfare or safety of a child they know or who is living in their area. This figure has increased by 8% since 2009. While 94% said people should become involved if they had concerns, of those who had been worried about a child 38% did not feel worried enough to tell anyone. This was not because they were afraid of repercussions or felt that it was not their business, but rather because of concerns about a lack of evidence or uncertainty about whether neglect is actually occurring. 37% of people would like more information about who to contact if they have a concern (up from 23% in 2009).

10 The Government must co-ordinate local services in order to encourage parents and the public to act early on concerns of neglect. We recommend:

- As part of the advice all new parents receive from maternity services and within their personal child health record, they also should be given information about the local parenting support services available to them.

All too often children have to endure a chronic lack of physical and emotional care over long periods of time before they receive help

11 Encouragingly, most practitioners appear to have heard the message that it is important to identify neglected children early. Yet, our review shows there are large numbers of children about whom a range of people may be concerned and who are known to communities and professionals but who are not actually receiving adequate direct help. Rather than slipping through the net, they are, in effect, stuck in it.

389 “The neglected child’s system of response to stress, through the hypothalamic-pituitary-adrenal axis (HPA), develops abnormally and this in turn results in increased vulnerability to a range of psychological, emotional and probably, physical health problems throughout the lifespan”: (Safeguarding Children Across Services: Messages from Research, C Davies and H Ward 2012).
12 Practitioners such as teachers and health visitors find it difficult to get a response to their concerns and social workers can get caught up in procedural issues. All are in danger of losing sight of the child. Key to effective help for children is that their plight is spotted early and that something is done quickly to help them. Yet in practice this is still not happening.

13 We found that 51% of social workers and 36% of police officers have felt powerless to intervene when they have suspected a child is being neglected. For social workers this figure has risen from just over a third since 2009.

14 When asked what the main barriers to this are they said that the point at which they could intervene was too high (42% for social workers, 23% for police officers). Front line practitioners have told us that there are not enough services to offer help to all the children at risk of, or experiencing, neglect. This view was clear from both the poll results (which showed that 43% of social workers and 28% of police officers thought that a lack of services was a barrier to helping children) and from participants in all the focus groups: “We know as social workers that early intervention can make a difference but it is still a challenge to get families into services early, especially when services are scarce.”

15 There is a tendency for some children and families to “bounce” in and out of services. Services are in place for a short time and then withdrawn when the urgency recedes. The clear research evidence of the need for longer term support appears not to have filtered through to service planning or provision.

16 Our findings show that, where funding cuts to services have not yet happened, the fear of cuts on cuts in the future is very real. This view came across clearly in the focus groups and is backed by evidence in the poll which showed that 80% of social workers, 51% of police officers and 44% of primary school staff think that cuts will make it more difficult to intervene.

19 The Government must increase children and families’ access to effective early support services. We recommend:

— In line with the Munro review 2011, the Government should clarify and improve duties for local authorities and statutory partners to provide sufficient local early help services.

What else would help neglected children?

20 We need commitment to long-term effective early intervention services measured by outcomes not outputs. What would stop children being neglected is access to personal support services in the long term, intensive support services for those in greatest need now and a move towards transforming service provision so that we have more low cost, high volume early intervention services and fewer high cost, low volume services for those in acute need.

21 Early support services need to be there for the long term. In the drive to reform public services commissioning arrangements must be revised so that any new family support initiative for children and young people must be funded for at least five years.

April 2012

Further written evidence submitted by Children and Families Across Borders

SUBMISSION ON PROPOSAL THAT ALL TRAFFICKED AND UNACCOMPANIED ASYLUM SEEKING CHILDREN BE MADE SUBJECT TO CARE ORDERS AS OPPOSED TO BEING ACCOMMODATED UNDER SECTION 20 OF THE 1989 CHILDREN ACT

INTRODUCTION

1. The trafficking of children is an increasing phenomenon and more trafficked children and young people are coming to the attention of local authorities and are becoming looked after.

2. At present the overwhelming majority of these children are accommodated under section 20 of the 1989 Children Act and are dealt with, legally, in the way that unaccompanied asylum seeking children (UASC’s) have been dealt with since the Hillingdon judgement. Save that the local authority does not get reimbursement rates for looking after trafficked children if they are not classed as unaccompanied asylum seeking children.

3. It is CFAB’s view that because all trafficked children, and indeed all UASC’s do not have a parent or carer to look after them, nor any competent adult in the UK with parental responsibility to agree to accommodation under section 20, they should be made subject to section 31 orders so that these children and young people have someone in the UK with parental responsibility. Section 20 requires the local authority to accommodate where there is not a parent carer under section 20(1) and it is only 20(7) where this can be done on a voluntary basis with the agreement of a parent/carer. It is not the section 20 provision that is legally wrong, but the fact that it is used for children whose profiles suggest serious harm/risk factors that would make section 31 the appropriate vehicle. Section 20 fails to provide these children with someone in the UK with parental responsibility.
4. “Unaccompanied children who are assessed by a social services department to be in need are cared for by a social services department under the provisions of the Children Act 1989.”

5. (Before the Hillingdon Judgement) local authorities had two options available to them. After an assessment, the child may be “looked after” or “accommodated” under the provisions of section 20 of the Children Act 1989. A “looked-after” child is entitled to have a named social worker, and is also entitled to things such as a care plan, an independent visitor and some continued support post leaving care. Alternatively, a child or young person may be “supported” under the provisions of section 17 of the Children Act 1989. The social services department assesses the child’s needs before concluding whether or not that child requires its support services. If it concludes that the child is “in need” of support, the social services department may decide, under section 17, to place the child with relatives, with foster carers, in a residential home, in supported local authority accommodation or in a hostel. Where a child is provided with accommodation under section 17, he/she is not classed as “looked after” for the purposes of the Children (Leaving Care) Act, 2000.

6. Section 17 of the Children Act, mentioned above, sets out the general duties towards a child “in need” by imposing a duty on the local authority to safeguard and promote the welfare of those children in its area who are in need. The local authority is under a duty to promote the upbringing of children by providing a range and level of services suited to the needs of those children. This may also include providing accommodation for the family of the child, assistance in kind and, in exceptional circumstances, assistance in cash (see amendment to section 17(6) of the Children Act, 1989 made by section 116 of the Adoption and Children Act, 2000, which came into force on 7 November 2002). Local authorities may arrange for some other organisation to provide the services mentioned previously, but the responsibility still remains that of the Local Authority. In contrast, Section 20 of the same Act imposes a duty on the local authority to “look after” a child in need. This may involve providing accommodation to a child in its area who is in need as a result of there either being no one with parental responsibility, no one able to provide suitable accommodation for the child or because the child has been lost or abandoned. In providing for such children, the local authority has to safeguard the welfare of the child and try to keep siblings together. Section 20 also provides that a local authority should maintain a service for those leaving care.

7. Under the Children (Leaving Care) Act, 2000, a person who was, before attaining 18 years of age, a child being “looked after” by the local authority under the Children Act, 1989, (either as an “eligible child” or as a “relevant child”) is classed as a “former relevant child” and is entitled to certain types of continued assistance from the local authority; in particular, advice and assistance in relation to employment, education and training until the age of 21 years. In some cases, this responsibility extends even beyond the age of 21 years. The purpose of the 2000 Act is to assist those young people who are moving from care to establish an independent living. It aims to achieve this by amending the Children Act, 1989, placing a duty on local authorities to assess the needs of this category of person, and to meet those needs.

8. Until 2003, when the Department of Health issued Local Government Circular LAC (2003) 13, most unaccompanied child asylum seekers were given support under section 17 of the Children Act, 1989. The 2003 Circular, however, stated that, as a matter of policy, unaccompanied children with no parent or guardian in the UK should be supported instead under section 20 of the 1989 Children Act:

(a) “where a child has no parent or guardian in this country, … the presumption should be that he would fall within the scope of section 20 (of the Children Act, 1989) and become looked after, unless the needs assessment reveals particular factors which would suggest that an alternative response would be more appropriate. While the needs assessment is being carried out, he should be cared for under section 20.” (Local Government Circular LAC (2003) 13)

9. The 2003 Circular adds that if an older child does not wish to be “looked after” under Section 20, then the local authority concerned might decide, after taking into account the child’s wishes, that the child is able, with the help of section 17’s support, to look after him/herself. The Circular was issued around the time of the Hillingdon Judgement, R (Berhe) v Hillingdon London Borough, [2004] 1 FLR 439, which was thought to have brought further clarity to an area that had previously suffered from some confusion. However, in January, 2005, a report by the Refugee Council, surveying 19 local authorities, indicated a disparity of responses by these authorities to the guidance provided by the 2003 Circular, thus suggesting a continued lack of consistency of approach towards unaccompanied asylum seeking children (Dennis, 2005). A further report in 2005 from Save the Children, building on the work done by the Refugee Council, echoed similar criticisms of the way in which local authority support to unaccompanied asylum-seeking children is being provided in practice (Free, 2005). Between November 2004 and May 2005 Save the Children contacted 18 representative local authorities in England and carried out detailed interviews concerning their responses to the Hillingdon Judgement and the 2003 local authority Circular 13. It was found that, out of the 18 authorities involved, one had been providing section 20 support to young unaccompanied asylum—seekers on arrival in the UK even before 2003, 11 had made the change to providing Section 20 support since 2003, whilst the other 6 were still not providing Section 20 support in this situation. As regards the longer term support of such young people, most of the 12 local authorities mentioned above continued to provide the more extensive Section 20 support after an assessment of the individual case had been made.
10. This transfer of support from section 17 to section 20 has undoubtedly put extra pressure on local authorities, but at the same time it is not a guarantee that the standards of care that each young person now receives is any higher than before. Clearly, resources are an issue here and some local authorities interviewed for the Save the Children report expressed concerns about the level of support which they were in practice able to offer under section 20. These concerns included the difficulty in providing social workers for all UASCs, not having personal education plans for all such young people and the quality and level of support being provided by some of the semi-independent contractors who provide accommodation in some local authority areas to UASCs. More importantly, young UASCs who should be transferred to the leaving care services team were not always transferred at the right stage because of resource difficulties. In all, the report presented a mixed picture of how those local authorities involved had responded to the Hillingdon Judgment and LAC 13.

Whilst there were many positive signs, there were also concerns expressed by the local authorities themselves about the support which they were able to provide to UASCs. Barriers to change centred on five main areas, the most important of which were funding, conflicting government policy and the difficulties encountered working with other statutory providers. Funding problems were a very significant barrier encountered to providing UASCs with the right kind of support and this problem related not just to the level of funding but also to administration of that funding. Conflicting policies emanating from the Home Office and the Department for Education and Skills (DfE), to which responsibility for UASCs was transferred from the Department of Health in 2003, however, are also a problem. A lack of joined-up thinking and co-ordination between the Home Office and the DfE has resulted in “mixed messages” and “conflicting agendas.”

11. An example of the sort of mixed message referred to above can be seen in the way in which the Home Office and the DfE approach the question of support to 16 and 17 year old UASCs. Circular 13 places emphasis on a thorough needs assessment of each individual case, which usually means providing section 20 support to most children in this age-band, but funding from the Home Office is half that for this age-band as compared to that available for the under 16 year old category. The end result is often that, whilst the local authority ought to be providing support to the 16 plus UASCs under Section 20 of the Children Act, 1989, there is insufficient funding available to do so.

12. Even within the DfE there are conflicting policies at work, which cause difficulties for local authorities. An example of this can be seen in the way in which the DfE excludes many young UASCs from having access to certain forms of funding which would improve the support which they receive under section 20 and under the Children (Leaving Care) Act, 2000. Both the latter, in combination with LAC 13, would suggest that most 16 and 17 year old UASCs are entitled to section 20 or to leaving care support, but these children may not, on the other hand, be entitled to a student loan or to receive education maintenance allowance which would facilitate that support.

13. Some of the local authorities interviewed by Save the Children were critical of the DfE for failing to provide adequate guidance and for not taking a more assertive role in relation to the Home Office. This had led to the Home Office taking the major role in a number of UASCs issues with the end result that immigration status was taking precedence above the best interests and welfare of the child. The report by Save the Children therefore concluded that, in practice, a significant number of local authorities, the Hillingdon Judgment and LAC circular 13 had not had a sufficient impact on the treatment of UASCs. Indeed, it would appear that section 17 support is still the main source of support for many UASCs, whilst the quality of service provided to these young people is often hampered by the limited resources available from central government to hard pressed local authorities.

(Paragraphs 4–13 from The Treatment of Children under the UK Asylum system—Children First and Foremost? L M Clements, BA, LL.M; Lecturer in Law, the University of Hull. L.m.clements@hull.ac.uk

See also:
Coram Children’s Legal Centre—Seeking Support a guide to the rights and entitlements of separated refugee and asylum seeking children.

Levelling the Playing Field—Finch and Brownlees

PROPOSAL

14. That all trafficked and unaccompanied asylum seeking children be made subject to care orders as opposed to being accommodated under section 20 1989 Children Act.

15. The reason for proposing this change in practice is entirely based on achieving outcomes which are in the best interests of the child, and meeting their safeguarding needs. These reasons are:

16. Trafficked children are more likely to go missing from care as they return to their traffickers through direct or indirect coercion. Discharging a missing child accommodated under section 20 is far easier than a child who is subject to a care order. It is envisaged that more careful placement decisions will be made if the
child is under a care order, and more proactive efforts made to ensure that they do not go missing and, if they do, that they are proactively searched for.

17. Trafficked children and UASC’s are uniquely vulnerable and this vulnerability is increased by them having no one in the UK who has taken full parental responsibility for them. Use of section 20 was not envisaged for children who have no contactable parent or guardian to give consent for their accommodation. Though guidance suggests that section 20 not be used if a needs assessment pointed to alternate options being more appropriate, there is little evidence that these children are being made subject to care orders.

18. Services provided for these children will be given higher priority within local authorities if the local authority has direct parental responsibility for them.

NUMBERS

19. At present only just under 600 children have been referred to the National Referral Mechanism (NRM) This is the Home Office body which determines, for immigration purposes, whether a child has been trafficked. The overwhelming majority of local authority social workers have never heard of the NRM so referral numbers are very low. International child protection issues such as trafficking do not appear on any pre-or post qualifying social work curriculum.

20. The 2010 annual UAS child new arrivals were around 1,500. The lowest for five years and a drop of 50% on the last four years.

21. The annual figure may also include a significant number of children who are not only asylum seeker children but trafficked. The most recent data provided by CEOP within their Child Trafficking Update (October 2011) states that 202 children have been identified as trafficked into and within the UK over the period 1 January 2011 to 15 September 2011.

22. Estimates on the numbers of unidentified trafficking victims vary and will include accompanied and unaccompanied children and young people. There could be up to an additional 3,000 trafficked children and young people in informal care arrangements in the UK.

23. Therefore the cohort potentially affected by this is potentially 1700 children and young people currently within the system and potentially up to 3000 trafficked children and young people coming to the attention of child protective services.

POTENTIAL BARRIERS

24. The barriers that may be preventing this course of action being followed are:
   — Cost of care proceedings (Norgrave review has addressed this if accepted).
   — Length of time for care proceedings to be concluded.
   — Capacity of Cafcass to provide guardians for increased numbers of care proceedings.
   — There are also practice and financial issues that may lead Local Authorities to resist issuing proceedings in respect of this cohort.
   — Concerns about rising leaving care service costs.
   — Concerns around rising placement costs if placement must be maintained for missing children.

CONCLUSION

25. The best interests of the child are clearly served most effectively by local authorities using the legal powers available to them to take full responsibility for UASC’s and trafficked children.

26. These children have no adult in the UK with parental responsibility, they have often experienced trauma both travelling to and once in the UK.

27. The reasons why these cohorts are not afforded the protection provided by section 31 orders seems partly custom and practice based, partly based on case law (Hillingdon judgement) and partly finance based (cost of care proceedings and looked after children costs).

28. CFAB would ask the committee to consider recommending that all unaccompanied and trafficked children are made subject to section 31 Care Orders

April 2012