Working Paper on Intervention against Child Abuse and Neglect in England and Wales[1]

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Part 1: The Intervention Sequence and the Response to Core Questions

1 Empirical data and case story

This working paper is based on two multi-agency workshops in which intervention responses to child abuse and neglect were explored (see background paper). Each workshop comprised two half-day sessions, and a focus group methodology was used. Participants were given a case story in three sequences to discuss. Six "core questions" were introduced during the discussions. The stories were agreed across the four countries, but adapted to fit the national context when necessary.

Participants in the workshops were: 2 magistrates (1 a former teacher), 5 statutory sector social workers, 1 teacher, 3 midwives, 2 voluntary sector social workers, 1 voluntary sector family support worker and 1 lawyer. It should be noted that recruitment of participants proved to be very difficult, in part due to pressures of work and staff shortages.

For the England and Wales workshops on child abuse and neglect (CAN) the story was as follows.

1st PHASE OF THE STORY

Adam, born on 3 January 2007, lives with his family. He is the first of three children. He has a younger sister (3 years) and brother (15 months). Adam is a very active child who is longing for the attention of his parents. Both parents find this can be wearying. His constant attempts to be noticed sometimes lead to a heated atmosphere. Quite often, the father rebukes him harshly. The mother sometimes sees the only way to stop Adam is to slap him.

2nd PHASE OF THE STORY

In school his teacher has concerns that Adam can be clingy and fearful of how adults respond to him when he asks for things or needs attention. She is also concerned about the black and gritty pictures Adam paints. She recognizes that Adam's mother quite often brings him to school late and that Adam is dressed the same for two or three weeks in a row. He often seems hungry and asks other children if he can share their snacks. Adam's teacher notices bruises on his arm and asks him about them. He

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explains that he was playing boisterously with his younger sister and brother, but the teacher is not convinced by this story.

The teacher slowly wins Adam's trust and one day he confides in her that a bruise is from being 'punished'. When she starts to ask further questions he becomes upset and pleads with the teacher not to tell anyone because he is afraid that his mother would be very angry with him and that his father will punish him. Around the same time the sister tells her nursery worker that Adam is naughty at home and that the parents have to show him how to behave.

The mother regularly brings the children to hospital. At one visit, when the paediatrician asks the mother about the bruises, she tells him that she sometimes cannot control herself and, also, asks for strict confidentiality.

3rd PHASE OF THE STORY

The teacher informs social services. They visit the family the next day and see Adam's bruises to his face and a welt on his butt. Social services initiate a medical examination and the diagnoses are haematoma caused by adult hands and being struck with objects like a belt or something similar.

When confronting the parents with the findings both mother and father deny that they have hit Adam with a belt or anything like a belt. However, the mother admits that her hand slipped once or twice but explains that Adam is such a difficult child. All attempts by social services to find out who used the belt to chastise Adam fail.

The family accepts support services. They cooperate and in May 2014 the social worker reports that the development of the three children has made significant progress, that the parenting skills of the parents are constantly improving, that the mother controls her temper better, and that the father disciplines the children in a more measured way. The relationship between Adam and his parents is characterized by increasing trust. Some concerns remain: the family struggles for money, the parents frequently cancel or reschedule the appointments and the apartment is not as tidy or clean as it could or should be.

After a sports lesson a teacher, again, notices bruises on Adam's back when he is changing his clothes. She immediately informs social services. Confronted with the information the mother concedes that her husband sometimes hits Adam with a belt. The father also admits this.

Temporary placement in foster care and initiating a criminal prosecution are under discussion. The case worker wants to call a case conference and to collect information from all the professionals who are involved in the family. Both parents refuse consent for the sharing of personal information. Social services also consider notifying the police.

2 Intervention pathways from the perspective of professionals

This section presents an overview of workshop participants' responses to the narrative above with respect to the ways in which a potential victim of CAN might enter the intervention system, any influence she/he or parents have on interventions, the sequence of intervention and the roles of different professionals within the intervention.

2.1 Routes of entry

> *Where a child is deemed to be at risk, the threshold for intervention is 'significant harm'. Referrals can be made by private individuals or other professionals such as health workers and teachers (CEINAV: UK Legal Context Paper).*

Whilst a small number of young people may self-refer, this is relatively rare. The majority of referrals to Children's Services come from other professionals, most commonly police, health (midwives, health visitors, GPs, hospitals) and education (nurseries and schools). In discussing the case story,

health and schools were presented as the most likely routes of entry, and participants from both those professions indicated they had a clear responsibility to gather information to ascertain, in the first instance, whether referral was needed, and to have the most evidence when doing so. Participants also indicated that they experience referral systems as increasingly bureaucratised, requiring completion of a lengthy form.

2.2 Victim or Parents' Influence on Courses of Action

In workshop discussions, the influence of parents and children emerged as limited, despite policy statements to the contrary. With respect to parents, participants reported that it depends on whether one or both 'cooperate', especially with Children's Services, and whether one is deemed a 'protective parent'. If there is an acceptance of professional concerns and a willingness to accept support then there may be some influence, especially if the intervention takes place under the Children in Need (see section 4 below) designation. Where concerns are rejected and/or the immediate safety of a child is at issue, the relationship is more likely to be adversarial and professional actions taken without a process of negotiation.

Whilst there is formal recognition of the voice of the child and participation, especially where the child is older, this will not prevent protective actions being taken where professionals deem this to be in the child's best interests. However, the reports on Rotherham (a city in which widespread sexual abuse of children, mostly girls, has been found) suggest that when young people have sought intervention, their request was not sufficient to trigger this.

2.3 Sequence of Intervention and Professional Roles

In Phase 1 of the story participants in both workshops agreed that either child health workers or schools were likely to be the first responders. Their responsibility here was to gather more information, through talking with Adam, his mother and other agencies. Here there was the potential for support, but this was not dwelt on for long in either group.

Representatives of child health and education saw it as their responsibility and duty to report concerns to Children's Services. The possibility of a referral to Children's Services was considered even at Phase 1, with a shared consensus across all those present that if there were 'marks' on Adam's body, a referral should take place. In some areas the initial process would be to discuss concerns with a MASH (Multi-Agency Safeguarding Hubs; see section 4) team. This would clarify if the threshold was met and, if not, what further information gathering might take place, and whether assistance might be offered through Family Support.

For Children's Services the key issue is whether the referral, and the evidence within it, is sufficient to trigger the threshold beyond which an investigation/assessment would need to take place. This was considered unlikely at Phase 1, probable at Phase 2, and at Phase 3 immediate action to protect Adam was deemed warranted. Where the threshold is met, social workers would talk with the child, preferably at the school, and not necessarily with parental consent. If the child discloses, then a medical examination would take place. The paediatric staff both stressed their role as being about the health and well-being of the child, which makes alliances with parents more possible. If there was a need for immediate protection a child could be kept in hospital overnight whilst further investigations take place, possibly including medical examinations for Adam's younger siblings.

An interim action might be to hold a Family Group Conference, which includes wider networks. If the parents cooperate this could result in a written agreement to change their behaviour, although this has no legal standing.

Once it has been established that the child needs formal intervention, how protection is put in place would depend on a number of factors.

- Is there a protective parent? In one workshop the mother was considered potentially to be this, in the other workshop less so – in this instance the father might be removed rather than

the child. Police bail was one possibility considered here, which could include a 'no contact' condition, but such arrangements are often 'negotiated' with parents, as an alternative to removal of the child.

- Is there domestic violence involved? If so, mother and children might be offered a refuge/shelter place, or other protective measures put in place with referral to specialist agencies.
- Where there is no faith that the child can be protected in the family, the child will be removed, under an emergency procedure, and consideration would be given first to placement with extended family or friends; if this is not possible, then with foster carers.

Following this a protection plan will be drawn up, which the parents will be asked to agree to. What happens to a child that has been removed will depend on whether the parents demonstrate the changes required for the child's safe return.

2.4 Participants' responses to core questions

This section sets out participants' responses to core questions following each phase of the above narrative. The extracts in italics represent quotes from participants.

(1) As a professional, what might lead you to try and discover whether this might be a case of CAN or, on the other hand, what might keep you from getting involved?

After a brief period of reflection, participants agreed they would take steps to obtain further information. There was no sense at all that any professional might not get involved, other than that their agency engagement might be further along the process, such as paediatric staff, social workers and lawyers. Some also referred to the behaviour of a child being an alert. In one workshop a midwife was articulate here about the 'gut feeling' you develop as a professional, that 'something is not right'. In such contexts, she said, you would consider a home visit and spending time with the child.

> *For midwives, it's a gut feeling and it's usually right... the way the mother interacts with the children or with me, if something isn't right, then we ask further questions. Usually it's about questioning the mother, is everything OK? (Midwife).*

A teacher similarly responded:

> *If there are physical signs like bruises, you can call social services or talk to MASH... but sometimes it's about discussing and being aware, communicating with teachers, with the school nurse... keeping an eye on the child. If they are known to social services or the MASH team then we continue to liaise with them and report to them (Teacher).*

There was consensus that they needed to know more, with some opting first to talk with Adam and possibly his mother, and others to find out from other professionals whether the family is known and in what ways.

> *The key word everyone has used is gather further information – health visitors, GPs – they may know how the family functions best and it's important to involve those people. MASH was set up for that reason, so you can get the information before you start to set up the services (Statutory sector social worker).*

There was some focus on how to identify whether Adam might be experiencing violence and, if so, its extent. Marks and bruises featured strongly here, reflecting the legal position: one magistrate expressed this as 'injury is pivotal'. In both groups there was a reflection on the boundaries between a 'smack/hit/punch' with differentiations made on two levels:

- motivation – was it frustration or a deliberate act;
- direction – what area of the body is targeted, legs or head.

The former in both cases indicated the possibility of less intrusive forms of intervention. Initially the latter suggested a formal approach.

> *I'm struggling, one thing I'd do, what is rebuking harshly or slapping, quite often I'd go back to what she actually does and what's your interpretation, because some people, they just slap on the legs, that's different from slapping on the face. So actually, there's something about going back to see what it means, rebuking harshly... and it might mean a referral on. It's the trouble with words, isn't it? And what do they actually mean by those words (Voluntary sector social worker).*

There was some consensus here across both workshops that further information would be sought and that most agencies would be involved at some stage of the information-gathering process.

(2) How might it come about that your institution or profession is the place to which a parent or child turns to for advice, intervention or support? Or how else might it happen that someone in your position would become involved?

There was very little engagement with either the child or parents seeking advice/support, rather attention focused on those agencies which would have regular contact with the child/family – schools (nursery possibly for the younger child) and child/family health services.

> *The health visitor would be the person who would be having regular contact and is probably in a position to give an overview of the family dynamics and it would be the health visitor with whom I would liaise in those circumstances and say, do you have additional concerns...if the health visitor was concerned, then escalate it. There are two levels, report a concern and keep it in the books, then a few weeks, another concern, a few weeks later, and another concern, then it's up to the social services manager to collate it at that point and take some kind of action, rather than jumping in with limited evidence on the first occasion (Paediatrician).*

> *It could come as a concern from the school. The school could contact the parents and discuss with them and refer the child on to other professionals within the authority – the behaviour support team, educational psychologist, and so on, and seek external support. If the school has – and a lot of them do now – a home support worker, that person could perhaps visit the home and discuss with the parents the issue of child management within the home...and would also look at how the other children are presenting (Midwife).*

Participating paediatric staff in both workshops considered a possible injury requiring investigation or referral about other health concerns might bring them into the picture.

For magistrates there would only be involvement if there was an application from the police for a warrant, or for an Emergency Protection Order (EPO) from social workers.

Participating statutory sector social workers indicated they would require a referral, and the evidence presented would need to cross a threshold before they took further action.

> *It would only get to my team if the child has a mark or made a disclosure. If we just got that (Phase 1 of the narrative), we would probably just signpost it to voluntary services to get support, maybe to CAMHS [Child and Adolescent Mental Health Services] to assess for ADHD, or if a parent or teacher was looking for advice; as it stands, we wouldn't take a referral on, it doesn't meet the threshold (Statutory sector social worker).*

> *There are so many things that can be dealt with at a universal level, that don't actually need a social worker and we are looking at championing the CAF [Child Assessment Framework], you know, the team around the family, so we have universal services and early intervention services going out to support schools and to support other... GPs, etc. on managing cases way before they even hit the doors of social care... so, the huge investment we have in early intervention is important as well (Statutory sector social worker).*

A social worker from a children's NGO indicated they may become involved through offering family support and other services but also pointed to the pressures on these services.

> *For myself, one of the downfalls of the system is that we don't pick these things up early enough… In my team, we're very reactive because we get inundated so we have to set the boundaries high, but there is a team working underneath us who can pick up early interventions (Voluntary sector social worker).*

Most participants agreed that a 'significant event' would bring about their involvement, the clearest indicator being a physical injury (see also earlier discussion about the health visitor and 'something not feeling right'). For professionals this was an important trigger.

> *Because there are bruises, it's quite clear that social services need to know (Teacher).*

Where a non-accidental injury was suspected, paediatric staff participants indicated they might choose to keep a child in overnight. They considered that parents would be more likely to accept this intervention as medical staff were positioned as having a shared concern for the child's wellbeing. While there was an obligation to make a referral to Children's Services, legal intervention was not inevitable.

> *I had a case like this when I was looking after a woman who was expecting her fourth baby and she was under a lot of stress, she was depressed, there was overcrowding and everything, then she disclosed to me that she's hit her elder child and what I did was to do a referral, obviously, there was a discussion with her and the social worker but actually what we did was put in a lot more family support, the school were made aware so they helped with that, she had a nursery school place for her younger one and everything came together just to reduce the amount of stress. So, we didn't necessarily need a social worker, we needed to have that discussion to say you are not allowed to hit your children and that was the end of that but what it enabled us to do was... it was a cry for help so we were able to put in support. It was a slow journey but it made a huge difference (Paediatric midwife).*

Another participant also felt it would be unnecessary to immediately involve Children's Services.

> *I'm just wondering – if there is a health visitor involved here, she's probably aware and knows something about the family. I see that as being the best point of contact. If I was the health visitor in this situation, this mother is distressed and tells me I hit my child. In that case, I will do a home visit, I will assess for mental health if she's at home with depression and I would make a referral [to adult services] (Voluntary sector social worker).*

Here, most participants could envisage being in a position where a child or parent might need advice or intervention. All would ask further exploratory questions which may, or may not, lead to a referral to Children's Services. If the threshold was deemed met, statutory sector social workers would undertake an assessment which would then determine the nature and extent of intervention.

(3) Would you consider asking the mother/father and/or the child, or what reasons might there be not to do so? How important do you think this is?

Different positions were taken in response to this question, both between the various professionals but also within the context of a conversation by one professional. Where a professional, such as a teacher, had an ongoing relationship with the child, or another such as a health professional with the mother, both groups agreed that further discussion was considered vital, at Phase 1, to establish what is happening.

In one workshop at Phase 2, health workers explored asking the mother about the Adam's clothes and the fact that the child is always hungry; in the other, participants felt that referral to family support services would open up possibilities.

In both workshops this led into conversations about consent, and that it is not required in the system in England and Wales, which sat in tension with a wish to speak about concerns with parents at each

stage of an intervention process. There was consensus that there was an obligation to inform parents, but it is unclear whether this applied to the information gathering and reporting of concerns referred to earlier.

In one workshop, and at Phase 2, the social workers present indicated they would want to talk with Adam, preferably at school, and with the teacher, in order to check what he actually said and whether his was a 'non-accidental injury'. They noted here that parental consent was not required, although it might be preferable to obtain it. Where it is known that there are marks, the legal framework justified action without parental consent, but here their main responsibility was to inform parents of what they were doing. If the police were involved, participants reported that they often advised against seeking parental consent as it might 'contaminate evidence'. For some, the issue turned on the question of timing.

> *One the things that's not very clear is the time scales. Is mum telling the paediatrician at the hospital the same time as Adam is telling the teacher at school? In that case I would speak to mum before going to see Adam just so she knows because there's this whole thing about speaking to the child without the parents' permission. I mean, I've now been in the UK for 14 years, and there's this whole thing about seeing a child before getting parental permission and how significant and severe it has to be before you go and do that. I think in this case I would probably speak to mum and say we need to go and see Adam with your permission (Statutory sector social worker2).*

Issues of confidentiality were also discussed. In one workshop there was a strong sense of adults having the responsibility to protect children: it was a case of 'safety first and foremost'. The fact that the child's wishes might thereby be overridden was dealt with through statements about making them feel secure and confirming that they were acting to ensure they were safe.

> *His safety is always first and foremost so, although he's said that, we need to make sure he's protected... and explain that we're doing this for him (Teacher).*

With some prompting there was a discussion about the possible difficulties for the teacher, where this betrayal of trust might damage the relationship with the child (see ethical issues below).

In the other workshop all felt a responsibility to share information across agencies if there were concerns and this overrode considerations of consent from any of the parties. Some dilemmas were introduced briefly, but were closed down by normative statements about safeguarding. This was further reflected in participants' responses to the next core question.

(4) When might you pass on information to relevant authorities or institutions without the consent of the parents and/or the child? On the other hand, what might keep you from doing so?

Information sharing was seen as a professional responsibility. In one workshop there was some discussion about the appropriateness of what you share related to privacy, but not whether you share if there are concerns about a child. This balance was seen as part of why the MASH was a good model, since it gave you the possibility to discuss if a referral was the appropriate step. However in both workshops access to MASH was raised, that the model made sense, but that it was often not possible to talk to someone.

> *Actually to track someone down for advice, who you can have that conversation with can be very difficult. Once you find them they can be fantastic but tracking them down can be a nightmare (Paediatrician).*

Once a referral is made, however, the nature of the information shared or, more accurately, the precision with which the concern was identified was raised as an important issue by a local authority lawyer.

> *With reporting I think, on the one hand, there's the question of professionals having a clear understanding of what is a concern, or might be a concern, and whether there is that trigger to report, but I think there's a real problem about precision in reporting. A lot of my social worker clients say this is the information which has come in from schools or whoever has made that referral. By the time I get to a point later in the week after the initial referral, the information is pretty different, and I think professionals need to understand that if you use the word 'punch', that is different from 'smack', it's different from 'slap', it's different from 'hit', and overzealous reporting is as dangerous as not reporting or under-reporting. It has a very negative effect on families, it leads to mistrust. I don't think it's wilful but people just giving the gist of things in safeguarding is really dangerous (Lawyer).*

In both groups references were made Serious Case Reviews (see section 4) where the failure to share information at the earliest point was considered poor practice. What was unclear was whether they would always inform the child or parents that they had passed information on. This was considered with respect to the requests from child and mother not to tell in the narrative, but was not always part of overall discussions about what they might do.

If child makes a disclosure, participants considered that it is seldom a one off, and therefore reported that in this context information should always be passed on.

(5) When could it be right/appropriate to initiate measures of protection from further violence, even against the parent/child's wishes? What concerns might prevent you from doing this or cause you to hesitate?

There was little hesitation in either group about this. In one workshop several participants considered court action to protect the child at Phase 1, when in fact little was known at that stage. Action was always considered justified where there was evidence of harm which met thresholds and there was no 'protective parent' with whom agencies could make an alliance. In this latter case measures of protection were considered possible that at least one parent, perhaps even reluctantly, would accept. If there was domestic violence this might involve placement in a refuge/shelter. Where the perpetrator is arrested, police are empowered to impose bail conditions which prevent contact with a victim. Alternatively, Children's Services may also seek an Emergency Protection Order to remove the child to a place of safety but this cannot include 'no contact' conditions unless specifically authorised by the court. In those circumstances it would most probably entail supervised contact following a risk assessment of the perpetrator.

Again in one workshop there was some reflection on this with respect to culture. The participants queried when it might be right to take action where there is no mutual agreement/understanding with the family. They similarly questioned how it could be known when enough support had been provided?

In the other workshop, by Phase 3, the fact that the child had been hit with an object – considered a conscious, deliberate act – was seen to necessitate immediate social work action to safeguard. In this group hitting was considered unacceptable, possibly a crime, and leaving a mark or using an implement were clear criminal acts about which intervention was mandatory. There was also some exploration of the longer term harm of neglect and possible emotional abuse of younger siblings who were observing maltreatment of Adam. All of these were sufficient for concern, which required further investigation and possibly, another referral, while Adam's rights were folded into the right to be safe, that is, not subjected to physical violence.

> *Removing him is the only way. It's his father who's doing it, possibly his mother as well, in removing him that will stop. The physical punishment has got to stop (Paediatric midwife).*

There was no conflict of mandates for any of those present: if the child is being abused professionals must act – whether that is a referral, an assessment followed by a plan, or a stronger, immediate intervention to remove a child from the family home. There was a very strong sense of there being

no choice for professionals, a 'bottom line', and that they should continue to refer even if Children's Services took no further action, although this was considered to be unlikely, as one participant noted.

> *If this came across my desk, quite a lot would have happened by the end of paragraph 2 and to get to the end of paragraph 3 [Phase 3] because, what would happen procedurally is that whatever explanation the parents gave about how Adam's injuries occurred would be put to a medic. And that might be done outside of court proceedings but very often cases would be catapulted into court of the basis of what's in paragraph 1. So, I don't know, I think these questions here would happen earlier on...so, if you had a medical report that the injuries were more likely than not to have been caused by being struck with an object, I don't think you would get a social worker or team looking at support for the family, you'd get a social work team looking at immediately safeguarding a child from further physical harm, and emotional harm, and looking at the other young children in the household (Lawyer).*

Another participant similarly reflected concerns about the other children in Adam's household.

> *Yes, where there's risk to one, there's usually risk to the others. There might be a chance that Adam goes home if things get better and the parents can demonstrate to us that he's not going to be at risk again...but it's very rare for us to let that family continue as they are without intervening at that point. (Statutory sector social worker).*

Some concerns were expressed at the potential damage intervention could do and whether removal was always in the child's best interests:

> *My criteria are, and it's always sad to have to take a child away, but am I going to do more damage by putting this child in care or leaving the child at home and, I hate to say it, but is it good enough? Because I know the damage that can be done in care (Voluntary sector social worker).*

This is further discussed below.

(6) What difference might or should it make if the family belongs to an ethnic minority? In what ways is this present in your work? Would your strategies of intervention differ in any way?

Both workshop groups had raised culture early on as an important factor in directing their thoughts about intervention. In the transition, however, there was an initial insistence that this would/should make no difference. The exception was whether interpreters might be needed and the complexities involved here, which was discussed in both groups.

Through discussion one group arrived at a position that, whilst principles had to remain constant, it was essential to explore one's own positioning and not to stereotype groups, since this may lead to making judgments on a different basis. This segued very quickly into a discussion about culture and cultural norms, focused on female genital mutilation (FGM), and that cultural norms with respect to hitting children might differ, which in turn led to thinking about early intervention being about education.

> *I think it's about both sides being educated. Even if you've come from abroad, you've come to live in this country and you've come from a country where it's ok to smack your children, but there's a level where you can't leave marks on your children. They can discipline their children but there's a level that they can't go above. There's no religion that says you can beat your children and leave belt marks. It's about educating the people when they come here about how they can discipline their children in the correct and safe way (Teacher).*

Another participant felt it was also about awareness and self-knowledge but that safeguarding issues should not be lost to cultural sensitivities.

> *From a health point of view we meet so many different types of people and usually families that have safeguarding issues, we tend to do a lot more one to one, working with them to build up a relationship. The important thing is acknowledging that people are different – we have a*

> *lot of Tamil speaking women and they won't look at you directly because they think they're being disrespectful – it's about understanding each other and I think, yes, we're all different, it is about knowing ourselves and recognising that we live in such a diverse society, [this area] in itself being quite unique, so it's about how we engage with others leaving who we are and our, some of our values outside and really working to our processes, knowing the law and, if it's statutory, knowing I need to do that and I think that's the challenging bit...we have to be quite versatile but it's a sensitive area but what worries me is that sometimes sensitive areas mean that you look at their culture, their colour more than look at the safeguarding issues (Midwife).*

In both workshops this discussion concluded that there needed to be a baseline, the welfare of the child must be the touchstone, otherwise it was felt that violence to children would be minimised in the name of culture.

> *I think it's important for professionals in an area... to have an understanding of the issues in different ethnic groups, you know, this particular ethnic group tends to behave in that way, and so on, so I think it's important that professionals in an area have an understanding of each of the individual ethnic groups. In [...] they do tend to have a cluster of Kurdish, Pakistanis but then to keep in one's mind always that the important, that the key issue is the safety of the children concerned and while it's all very well for them to follow their cultural norms or whatever but they should never ever come above the safety of the child (Midwife).*

There was also a stronger sense in this workshop that 'culture' - which belonged to other groups, rather than also themselves (this group, unlike the other, comprised all white professionals) - was more patriarchal.

> *I think it depends on who the family is and where they come from...if you have a very big family network...you would included the extended family but if you have a family from Pakistan where it's acceptable in their culture for the man to hit the wife, it's also about working with the husband, the father, to tell them it's actually not acceptable...you still treat them with respect (Statutory sector social worker).*

> *With cultural sensitivity, culture is something that's important to you, not for me. It's not going to cause any problems for me to go along with this...to take my shoes off at the door and things like that. That's just one example, and there's lots more...and it's just about saying, I do respect your culture...but still being clear about the bottom line (Voluntary sector social worker).*

As in the other group, then, participants expressed clear feelings that cultural norms should never trump child safety and that the focus should always remain on the child.

Part 2: Framing of the Problem and Intervention

3 Framing child abuse and neglect

3.1 Key frames in legal and institutional documents

This section sets out the legal and institutional frameworks relevant to child protection law and practice. Extracts in italics are taken from an internal document, a legal context paper, prepared by the UK research team.

3.1.1 Legislative frameworks

The primary legal instruments governing child protection are the Children Acts of 1989 and 2004 (CA 1989; CA 2004). A new piece of legislation, the Children and Families Act (CFA) 2014, has also very recently been enacted.

The CA 1989 introduced a number of key concepts, including the 'welfare of the child' and 'parental responsibility' (to ensure and promote the welfare of the child). Where parents fall short, s17 of the CA 1989 imposes a general duty on local authorities, through Children's Services, 'a) to safeguard and promote the welfare of children in their area who are in need, and b) 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.' Hence, the 'child in need' designation links to interventions which offer support through multi-agency assessment, planning and review. Many of these are universal services, for example, health, but some are more specifically forms of early intervention and family support, and non-governmental organisations (NGOs) with voluntary sector social workers often play a significant role. Austerity measures by the current government have reduced the capacity of such services, a point noted in the workshops.

Although there is often considerable fluidity between the two, 'children in need' is a broader concept than a child at risk of 'significant harm', also introduced by the CA 1989. Here, s47 provides that where Children's Services 'have reasonable cause to suspect that a child...is suffering or is likely to suffer significant harm, [they] shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide what action they should take to safeguard or promote the child's welfare.' This may include a court application for an emergency protection order (EPO) to remove the child to a place of safety. All other agencies and professionals in contact with the child are obligated to cooperate and assist Children's Services with their enquiries. In addition, s46 of the CA 1989 confers powers of police protection. These enable a police officer who has reasonable cause to believe that a child is likely to suffer significant harm to remove that child to a place of safety for a maximum of 72 hours. No court order is required but the local authority must be informed.

The CA 2004 also introduced a number of key provision; in particular, it:

> *- established a Children's Commissioner to champion the views of children and young people;*
>
> *- imposed a duty on local authorities to promote inter-agency cooperation;*
>
> *- required local authorities to establish local safeguarding children boards (LSCBs), replacing Area Child Protection Committees (ACPCs)[2]; and*
>
> *- created an integrated inspection framework to assess progress in improving outcomes.*

The newest piece of legislation, the CFA 2014, entered into force very recently and too late to impact on professionals taking part in the workshops. However, reference was made to a provision introducing a 26 week period (see below, section 6.2) for concluding care and supervision proceedings in court.

While the CA 1989 and 2004 and, most recently, the CFA 2014 provide clear legal frameworks for enforcement of child protection interventions, criminal law is less clear.

> *Specifically, corporal punishment of children in the familial home is still widely regarded as legal. This is correct to the extent that it is not specifically criminalised, although any assault on a child can be prosecuted. However, in certain circumstances, parents may raise a defence that their actions constituted 'reasonable chastisement' and caused no visible injury to the child.*

Visible injury thus comes to represent a threshold, with 'marks' and 'bruises' key differentiators, indicating possible significant harm. This is discussed further below.

3.1.2 Policy, guidelines and institutional frameworks

As indicated above, the CA 2004 introduced an integrated inspection framework. With respect to this provision, the Office for Standards in Education, Children's Services and Skills (Ofsted), is an

[2] The primary difference between LSCBs and ACPCs is that as of 1 April 2006 all organisations that work with children are legally required to participate (in LSCBs).

independent body which reports directly to parliament. It carries out inspections (often unannounced) and regulatory visits to local authority Children's Services departments to assess the quality of work undertaken and to rate performance, for example, as good, or as needing improvement. Where a local authority is deemed to be failing it can be put in what is known as 'special measures' which may involve the replacement of staff and the provision of additional resources to ensure standards are quickly improved and performance targets are met. This is an essential oversight mechanism, although there continue to be cases which fall through the net. Where this occurs, Serious Case Reviews (SCRs) must be conducted. These are undertaken by LSCBs where abuse or neglect is known or suspected, and a child dies or is seriously harmed and there are concerns about how agencies and professionals worked together to protect the child. The obligation to carry out SCRs is set out in revised statutory guidance, Working Together to Safeguard Children (2013) published by the Department for Education. It specifies that SCRs should be completed within six months but also provides guidance on how agencies should work together to safeguard children and promote their welfare, as well as how practitioners should conduct assessments (of children and their families).

This is not only required reading for all professionals working with children, it is also useful guidance, more so as 'significant harm' is not further defined in law. There are, therefore, no absolute criteria on which Children's Services can rely in judging what constitutes significant harm. Where a child is deemed to be at risk, an investigation and assessment will be made considering the severity of the ill-treatment which may include the degree and extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence of threats, coercion, sadism, bizarre or unusual elements in the treatment of a child. Sometimes a single traumatic event can constitute significant harm (such as an assault) but more typically it is a compilation of significant events, both acute and long-standing. The investigation will include gathering information from all known agencies and professionals in contact with the child. Further, the need to protect a child must be recorded on a local authority integrated electronic register of children, the 'Integrated Children's System (ISC) (formerly the child protection register) under one or more of four categories: physical abuse, emotional abuse, sexual abuse or neglect. Additionally, Children's Services have a duty to create a 'child protection plan'. Decisions about any plan are taken at a child protection conference, convened and organised by Children's Services, and usually attended by all relevant parties including parents and, if appropriate, wider family, a range of professionals from health and education, as well as Children's Services and police. A social worker will have prepared a report following an assessment of the child and family and the initial child protection conference will establish whether the child in question should be made subject to a child protection plan and, if so, under which category. Further decisions will then be taken with regard to the actions to be contained in a plan. Child protection plans are kept under regular review.

Legal proceedings to remove a child to a place of safety will be initiated only when it is deemed not possible to mitigate and manage the risk through making the child subject to a child protection plan. Some NGOs are also empowered to remove children but do not generally have access to foster care placements and the case is invariably referred to Children's Services. Removal may be on a temporary basis, most typically to foster carers, but may also result in the child remaining in the long term care of local authority foster carers or, in some cases, in adoption of the child.

The lead agency is always Children's Services, comprising statutory sector social workers, unless there are concerns about parents fabricating children's illnesses, in which case the health service will be the lead agency. On some cases, social workers will work closely with police, undertaking investigations jointly, but all child protection referrals go to Children's Services. How they are organised varies by local authority, but there is always a very strong multi-agency framework, within which information sharing at all points is expected and mandated. The most recent organisational change reflects this, namely MASH (Multi-Agency Safeguarding Hubs) teams, in which social work, police and health staff are co-located and act as both an early advice point for other professionals to share concerns and a triage system for referrals with respect to children and adults.

3.2 Key frames from the perspective of intervention professionals

Workshop discussions were informed by a strong normative consensus around law and child protection guidelines which defined the problem and the appropriate intervention. In keeping with this, the main themes to emerge were risk to child safety/professional responsibility for safeguarding; and multi-agency information sharing and cooperation. An underlying theme which ran throughout both workshops was that of culture. This is discussed at section 5.3 below.

It is also important to note that both workshops took place a week after a major report was published about the failure of state agencies to protect thousands of children, mainly girls, from sexual exploitation in a northern city – Rotherham. This is the third city to issue a report focused on what have been termed 'Asian grooming gangs', a model in which groups of loosely connected Asian men organise the prostitution of mainly white young women who have been in local authority care. This was a backdrop, which was referred to in the workshops. It is only the latest of a series of reports, including several high profile SCRs which have criticised the actions (or more accurately in-actions) of a range of agencies with responsibilities for child welfare and child protection. This wider context has a profound impact on how professionals think about cases. It should also be noted that all political parties are likely to support mandatory reporting of child abuse for professionals and citizens/residents in the election campaign next year.

(1) Risk to Child Safety/Professional Responsibility for Safeguarding

Many, if not all aspects of intervention, were typically framed in terms of these concepts which together constitute a key frame in the UK, discussed by all professionals considering if, when and how to intervene. Thus risk and safeguarding are two sides of the same coin, deriving from legal, policy and institutional frames (see above). It should be noted that professional responsibility is not the same as intervention – it is professionals' perception of potential or actual risk combined with their understanding of their professional responsibility which may trigger an intervention pathway. Hence, professional responsibility is not a framing of intervention but a pre-condition for potential intervention, predicated on a perception of risk.

The level of perceived risk to a child informs the nature of intervention. While some participants indicated that any concern would cause them to contact Children's Services, even where the threshold of risk of significant harm was not met, others only 'escalated' their actions where they found evidence of marks or bruises on a child's body which was understood to potentially constitute significant harm.

> *Where I'm working at the moment there's a family support centre. It would depend, I would look for early help or family support services. I would do that first, not children's social services, because it's the mother who is disclosing and who wants help and support to stop that from happening again (Voluntary sector social worker).*
>
> *We look, for example, if we spot bruises, if it raises concerns then I would actually escalate. Sometimes I speak to the MASH team and say, I have concerns (Midwife).*

Even so, the safeguarding mandate was accepted by all in both workshops as a shared responsibility, with a strong expectation and, in some sense a requirement, that 'concerns' are shared with Children's Services. Professionals are thus tasked with ensuring a child's safety, with appropriate law and systems in place to guide decisions and interventions: considerable faith was placed in procedures and processes, if implemented consistently across agencies.

> *I'm absolutely clear that safeguarding is everyone's business. That's a line that we all use but everyone around this table gets involved with adults and children at some level and has an understanding of when to report and I think the most important thing is picking up that phone to MASH or anyone else. It's also an advice line, not only when you're referring in (Statutory sector social worker).*
>
> *… the welfare of the child takes over, everything else falls away (Midwife).*

…if we all follow our procedures we've hopefully got that little boy safe (Paedriatric midwife).

Subframe (1a): Striking a child is unacceptable and potentially illegal

A sub-frame to emerge here was to consider hitting or striking a child as a criminal offence. This arose in both workshops but was particularly strong in one workshop, where it sat underneath both the standard that hitting children was unacceptable and warranted intervention, and discussions of the potential need to 'educate' migrant families. Initially, in this group there was an unchallenged assertion that any act of hitting a child was a criminal offence although this was later qualified.

> *It's the risk, the risk is if Adam is being hit on the head, then it's a criminal offence so therefore somehow that needs to be communicated to the parents, but it might be a slap on the legs which is different and I guess, for me, part of the difference is the level of control...but there is a bottom line if the child is being hurt (Voluntary sector social worker).*

It was therefore acknowledged that hitting a child is not necessarily illegal but this ambivalence over majority 'norms' has implications for how these are communicated to parents. Nevertheless, an emotive statement about how many accounts, including from Rotherham, there are of children disclosing to professionals but nothing being done was widely supported.

There was some discussion in one workshop of the burdens on children if cases are prosecuted - having to give evidence against a parent, and whether such processes can be deemed to be in their best interests. The differential time scales of family court and criminal court procedures were also raised and whether these two systems can effectively operate together.

> *Where there's family proceedings and criminal proceedings...the family court doesn't wait for the criminal court and anyway you have a different standard of proof. Quite often, the minute our proceeding is over, you know, the finding of fact, the police request our report, the decision the judge has made...it always feels really artificial if a parent still has a criminal case hanging over their head and may be convicted of something, I suppose partly dependent on what the sentence could be, there is something really artificial about making decisions about the child's life in isolation from what is happening in the criminal justice system. Ideally, what was supposed to happen was that the tribunal hearing the family case should be the same tribunal hearing the criminal case and there would be this link and there would be the same kind of timescale but the reality on the ground is that I don't think the police and the CPS can work to the family tribunal timescale and the family timescale can't be delayed. There isn't that ribbon through it... it's really hard to see how those two systems can sit side by side really (Lawyer).*

For all participants, then, safeguarding equalled making Adam safe from physical abuse and within this the 'best interests' or 'welfare' of the child legitimised professional intervention, and limited debates as to what might be a child's best interests. The child welfare NGO and a local authority lawyer in one group were the most willing to explore that law and policy might not deliver the best interests of the child (see ethical issues below).

(2) Multi-Agency Cooperation and Information Sharing

In both workshops it was apparent that the intervention process was predicated on multi-agency cooperation and information sharing, with these concepts again representing two sides of the same coin. Intrinsic to multi-agency cooperation was the notion of information sharing among professionals, and vice versa. This frame ran throughout both workshops, commensurate with the overarching legal and policy framework and with obligation of all relevant professionals to discuss concerns about children with MASH and to make a referral to Children's Services. In this context multi-agency cooperation and information sharing was deemed a necessity.

> *It's very much about people getting together, professionals coming together to give their part of the story, their piece of the jigsaw...It's all about that information, we all need each other...I cannot tell the story without someone else there to help me paint the whole picture. But it's about not being frightened to give your part of the picture. It's actually about taking that*

information, mandatory, and doing what we as professionals are taught to do, and whether it's right or wrong (Midwife).

I think it's very straightforward from the beginning. It's a referral from the teacher in the first paragraph and again, you refer again, after the second paragraph. The nursery worker, she should pick up the phone to the school, just to say this is what the sister said. Then you've got more information, then you refer again. The social worker has got to have as much information, you know, the more you give them...and the easier it is to safeguard, and when it gets to the paediatrician, he would be admitted. If he's got bruises and the mum is admitting she caused them he'd be admitted as a place of safety, then you'd ask the social worker to come and talk to him on the ward. You've finally got that little boy safeguarded (Paediatric Midwife).

The focus, however, is on other professionals cooperating with Children's Services, as the lead agency which may, in turn, run any investigation as a single agency or jointly with police.

Well, I think, especially if there are bruises it should be referred to us straightaway and we would see if it's single or multi-agency and go out and speak to Adam. If there's bruises we wouldn't need to get parental consent but we'd need to get further information from Adam about how it happened because sometimes you get referrals like this and it's completely different when we get there and speak to the child. But we'd do a thorough investigation. We'd need to do welfare checks with everyone – GP, teacher – we'd have to get a medical examination, we'd take Adam to the hospital to see if it's accidental, accidental injuries and then, yes, we'd be speaking to the parents as well...after speaking to Adam. It depends, if there's a joint agency, I had a case like this the other day and the child disclosed it was dad so I had mum meet us at the hospital and the police arrested dad. Then there were bail conditions of no contact with the child to keep the child's safety paramount. It's a lot for a child to go through and a police officer coming to speak to them at school is obviously quite scary but you have to use your techniques to get the information. You're often very time restricted as well which is difficult but this is the process...we have to ask very open-ended questions, we can't ask leading or closed questions, you have to get them to tell you what happened...if there are bruises and the child's closed up, you talk to the person who made the referral, that the child spoke to, and we'd still go ahead with the medical (Statutory sector social worker).

Multi-agency working was also seen as reassurance to social workers, particularly when there was a possibility that a child would have to be removed from the family.

It's a massive anxiety, I really struggle, but where the chances are real...you know that's why it's so important to me that it's as a conference, as a group thing, that you've all got to discuss and make sure you're not the only one that thinks this and that's kind of how I deal with my anxieties. At the end of the day their safety is paramount and it's your job to make sure they're safe (Statutory sector social worker).

Here, it clearly emerges that multi-agency cooperation and information sharing are an integral part of child protection procedures.

4 Framing culture and difference

In one workshop there was a complex and nuanced exploration of culture – as a potentially important piece of information to consider with respect to interventions with families, and a critical consideration with respect to practices such as FGM. On the other hand, there was widespread discomfort with the concept, since it ran the danger of stereotyping and homogenising social groups and failing to look at the individual child, where issues such as their age and gender may be equally, or more, salient considerations.

> *I think there's a little bit of a danger when you place issues of culture or ethnicity in such other separate categories. You move away from the fact that when you have a child in a family you might have a series of lenses that you have to approach looking at the child or working with the family through so, if the um – whatever her ethnic origin – is a very young mum...how does that affect her interactions with e, how does that affect her understanding of the process, how is that influencing her attitude towards parenting...Culture is another, very necessary, but just one other lens through which you approach the case and one question could be whether this is a function of a cultural norm, but it need not be, it could just be about that individual family* (Lawyer).

Another participant agreed that culture was just one of several factors which needed to be considered while urging caution over 'political correctness'.

> *I think cultural issues are just one of the factors that we have to deal with...in the Victoria Climbie case, people in the housing part of social services realised that the aunt spoke harshly to her but they didn't think it was their place to tell their colleagues even though social services were next door. The nurse on the ward, who spoke French knew she was scared of her mother's new boyfriend, but didn't think it was her place to tell her colleagues, and we still find this in our own work...so, being politically correct is helpful and unhelpful, it's just one of the factors we have to deal with* (Paediatrician).

These interactions prompted further discussions of '*culture talk*', which was considered common amongst health and social workers. Here participants were exploring how slippery 'culture' is as a concept: it can stand for 'not white', 'not British', or being from the same country/sharing an ethnicity and/or a religion. So it can be about origins/heritage, identity, beliefs, all of which then become associated with 'norms', norms which are culturalised.

One social work participant felt that cultural differences might be a source of strength but also queried the use of cultural experts and considered that families might comply with the law without having any understanding of the rationale behind decisions. She raised several fundamental questions: what is culture? what does it mean? what are we saying is different?

> *I trained in a different country and have seen a diverse range of views and when I came to practice in the safeguarding field here, it was a completely different experience for me. I struggled constantly in terms of my understanding in looking at family situations and family functionality. It's very tough but cultural differences can also be strengths in certain families. This has to be differentiated from where there's abuse happening. Sometimes we go over the historical background and pick up all these aspects. We talk about it at referral and there it's taken care of, it's not something that's assimilated into our assessments. Instead, we bring in [cultural] specialists and I don't know what it means. I wonder, given what I've learned, whether I could do it, but we expect people to develop that level of understanding that their cultural practices are not in line with what we see as safe parenting. People don't understand it because they know differently from generations of experience and then they do as they are told without understanding* (Statutory sector social worker).

In the other workshop, discussions focused more on recent immigrants and a need to educate them, often through the use of interpreters.

> *You've got to put a lot more effort in, working with interpreters, to make sure they understand, just to get the quality of intervention...you've got to have that connection, making sure everyone's aware of the different cultural norms, particularly with foster care, it's seen as number one priority, to get a cultural match with the child* (Statutory sector social worker).

Another participant also stressed the importance of ascertaining legal status and being clear about the law which could potentially be of use, especially to women.

> *First thing you need to know is their legal status in the UK because there are different rights for different people, language, interpreters...which is slow because social workers have to have*

> *face to face meetings but getting an interpreter is so important...the right interpreters...and being clear about what the law is in the UK. Women with domestic violence actually love how strong the law is, it just means that they can break away from that* (Paedriatric midwife).

There was also a greater sense in this discussion that culture was understood as something which belonged to others (see section 4.6) but as in W1, participants agreed that the focus on the child had to be maintained.

> *You have to be sensitive to culture but you can't work differently with different cultures...and it doesn't matter where you're from – if you're from Africa or Lithuania - ...so you might work differently with families around what is acceptable there and what is acceptable here but you still focus on the child* (Statutory sector social worker).

Hence, while there were somewhat different understandings of culture in each workshop, all participants agreed that issues of culture or cultural sensitivities should not distract from their primary safeguarding roles and obligations.

Part 3: Ethical Issues and Dilemmas from the perspective of practitioners

This section explores the ethical issues and dilemmas raised by participants during the course of discussions, either directly or implicitly.

5 Ethical issues in the workshops

5.1 Practical Dilemmas

Additional practical dilemmas were raised by participants. These overlap but were nonetheless distinct from ethical dilemmas in that professionals addressed them in terms of 'practicality'.

5.1.1 Working with the 'engaged' parent

Some suggested that professionals were more likely to work with mothers. This was not necessarily considered right but they did so because experience taught them that mothers were more likely to be protective and to engage in the intervention process.

> *We don't always but we tend to say mum because it's about the protective parent which I think, I'm not saying it's right that we always work with the protective parent, but that is generally what does happen, you know, because they're the one that's engaging, the one that's seeking help. That's what you see, you've got access to that family through that protective parent and therefore you do work with them* (Voluntary sector social worker).

5.1.2 The effect of domestic violence on the intervention process

Professionals perceived the possible existence of domestic violence to raise practical questions for them, in particular, 'can the mother still protect the child?' And 'how to work with a family where criminal proceedings may be pending the outcome of which is unknown?' Hence, where professionals suspect domestic violence, this can affect how they engage and the routes of intervention.

> *There's another element now* [of domestic violence] *so it could be a case of mum asking for help in taking the children to hospital, but she can't say so in so many words. So another question now is how is mum going to protect the child and this might change how we analyse the case* (Statutory sector social worker).

Another social worker confirmed it would in fact change the way a case was approached while a lawyer noted the possibility of two separate routes.

> *If it's domestic violence, it's about power and control and there are specialised treatment programmes so you would go down two separate routes although they might overlap* (Lawyer).

A magistrate pointed out, however, that this is not always straightforward.

> *As magistrates, we're just dealing on facts. We're the end of the line so if dad is a perpetrator of domestic violence and he comes to court, the tensions are if you're family, youth or general. We're not there as social workers, our purpose is to uphold the law, we're the end of the line. If the evidence is not there, we can't convict* (Magistrate).

5.1.3 The consequence of diminishing/diverted resources

In one workshop, it was pointed out that family centres, which used to provide early intervention and support, are now mainly focused on child protection, such that there are fewer and fewer resources for children in need, particularly for those with mental health issues. As one participant noted:

> *Regarding CAMHS, you can make a referral but it might as well be to Father Christmas* (Voluntary sector social worker).

5.2 Ethical dilemmas

5.2.1 Consent

Child protection requirements can stand in tension with issues of the child's or parental consent – to interventions and to information sharing, as well as to the amount of information retained which was deemed at least potentially detrimental to a child in later years.

With respect to children, this was explored as both a practical and ethical dilemma for teachers, and anyone else a child trusted sufficiently to make a disclosure to – the tension between the trust that had enabled a child to tell and the safeguarding responsibilities of professionals. In the first instance, this concerned acting without or against a child's consent.

> *I've had this experience myself, that a student has felt I've betrayed them because I've reported. It's really complicated and hard [but] we'd say we need to tell someone to make sure he's ok, in appropriate language, and that he did the right thing in speaking to an adult (Teacher).*

Hence, professional responsibility requires professionals to report concerns about a child's welfare even without the child's consent and even where this might breach the child's confidentiality with the risk that child may lose trust and/or no longer disclose.

Other participants addressed the dilemma of acting with or without parental consent, as well as the difficulties for a child. Professionals are tasked with working with parents which can create tensions with their responsibilities to safeguard children and which may entail sharing information with other agencies without parental consent. This was also perceived as a practical dilemma in weighing the various repercussions with respect to the child and any future cooperation of parents.

> *I think that's one of the practical difficulties, how you make decision, whether you do it with the parents' consent or without the parents' consent. There's the whole idea about working with parents...but a child like Adam might close up and never disclose anything ever again – 'cos I told you I was scared of my parents'...so, there's all the repercussions, they have to be weighed* (Statutory sector social worker).

> *That's an interesting one where it says both parents have not given consent to share information...by the time it gets to conference level, the threshold's been met to share information because if you don't, it's detrimental to the child so, despite those parents who*

> *may attend the conference saying they're not willing, I think decisions do need to be made to share it in a conference* (Statutory sector social worker).

Another participant, however, queried the extent of information sharing and the duration of its retention. While documenting information was deemed a vital part of child protection procedures, it might be excessive; it was further suggested that significant amounts of information were kept on file which may compromise privacy rights and have an adverse impact on a child later in life. Hence, there was a dilemma balancing these obligations and rights.

> *I don't know whether in our system there's always full consideration of what needs to be shared, whether there's proportionality. If we're at the threshold of where we need to share information, it's almost wholesale and every detail of that family's life needs to be shared with every other agency and I think there's a real issue. A child might want to see a report later in life for therapeutic reasons but actually half of it's about the parents or another child and I think that should be redacted...I think the dilemma here is that people have a right to privacy and that right to privacy and that right to family life has to be balanced against the legitimate aim of child protection* (Lawyer).

Here it is acknowledged that child protection mandates can stand in tension with issues of consent, particularly where the child's wishes must be overridden and, again, with issues of confidentiality and rights to privacy for all parties involved in child protection proceedings. These tensions create both ethical and practical dilemmas for professionals tasked with securing the best interests of the child, immediately and in the longer term, discussed further below.

5.2.2 Best Interests of the Child in the Short and Longer Term

In both workshops, the best interests of the child were deemed met by ensuring physical safety but consideration was given to the possibility that procedures and guidelines might take you in directions that were not always or necessarily in a child's best interests.

> *We have a case, it's still on-going. It's about assessing the welfare of a child versus a criminal investigation. The father's not allowed back in the home but our feelings are that the welfare of the child is more damaged by removing the father. He* [the child] *is now withdrawn* (Statutory sector social worker).

In W1, there was also concern that removal from the family home may adversely impact a child and may not be in a child's longer term best interests, particularly when trying to balance physical safety and emotional well-being. Within the context of current statutory social work, the proportion of children who are subject to legal proceedings is significantly lower than those who are subject to child protection plans where risk is managed using a multi-disciplinary approach while the child remains at home. However, the relatively small number of children who are subject to legal proceedings face a child protection system which has become increasingly risk averse, and with decreasing resources for therapeutic work. This raised the question of what the welfare of the child actually means in practice when care proceedings are deemed necessary.

> *There's a huge part of this that's about who inherits the risk, of balancing the risk of physical harm against emotional harm and weighing the detriment of a child being removed against removing a parent and leaving the child in the precise scenario in which the harm happened. But the reality on the ground in this day and age with all your negative publicity about various professions in child protection, you'd be hard pressed to find social work teams who would say leave a child there and you'd be hard pressed to find courts that would say leave the child there. Everyone is so risk averse and even in those finely balanced cases, you come down on the side of caution* (Lawyer).

This was echoed by participants in W2. Here, it was also acknowledged that removal may not always be in a child's longer term interests but, nonetheless, immediate physical safety was paramount.

> *I think you could acknowledge there's been improvement but I think you've got to be very focused on the child's timeframe and the fact that he's still got bruises, there's still risk to his safety. You've got to put measures in to address that because obviously things aren't working completely so the child's safety is paramount so it would probably be a discussion of foster care* (Statutory sector social worker).

Participants also anticipated this dilemma intensifying with the introduction of a new 26 week time scale for concluding legal care proceedings and some queried its express intention to be child focused, with concerns that decisions might be rushed and that parents might have insufficient time to demonstrate necessary changes. This ethical dilemma was summed up by a magistrate in commenting that resources were there for the legal processes but not for universal support services.

6 Summary

The dominant themes in both workshops were risk and a safeguarding mandate shared by all professionals. In practice this meant that any health care practitioner, teacher or other professional coming into contact with a child had a responsibility to report concerns about a child's welfare or well-being to Children's Services (most recently through MASH). Some anxiety was apparent in breaching a child's confidentiality, particularly where a relationship had formed between a child and the professional, with fears that the child might subsequently withdraw, but these anxieties were secondary to safeguarding issues. The threshold for referral was invariably a physical mark or bruises on a child which appeared to be non-accidental and/or the child's (or parent's) disclosure. This would not necessarily trigger intervention by Children's Services but, depending on the information relayed to statutory sector social workers, might instead lead to a less intrusive form of involvement by way of family support services. By contrast, if a referral is made evidencing more risk of harm, this would meet the threshold for statutory sector intervention and trigger a process of investigation involving all professionals working with the child in question. Following a detailed assessment, a child protection conference would be convened, and a plan might be put in place which would be kept under regular review, with support and assistance to parents to make the necessary changes to ensure the safety and well-being of the child. Where parents fail to cooperate, to change their parenting behaviours and/or the risk to the child is perceived to escalate, or constitute significant harm, court action may lead to the removal of a child from the family home. Significant harm is assessed as more significant or repeat non-accidental injuries causing visible marks or bruises to the child although there are also categories of harm – see above, section 4.2). During the statutory investigation period, a suspected perpetrator may be arrested and bailed on 'no contact' conditions while the child is left with the 'protective parent'; if this is not a viable option, as indicated, the child will be removed from parents and placed in temporary foster care. This can include placement within the extended family if prospective carers are assessed as suitable.

Multi-agency work, led by Children's Services, is the norm, with strategy meetings and case conferences. Information gathering is intrinsic to this process, and other professionals have a legal duty to cooperate with Children's Services. Child or parental consent to the investigation is not required although parents are invited to attend case conferences and are entitled to copies of all reports. Participants in the workshops expressed little concern about multi-agency information sharing although one participant felt there was a lack of proportionality in the system and that sections of reports should be redacted following conclusion of legal proceedings as children were, later in life, entitled to request and have sight of these reports.

In both workshops there was general consensus that 'the best interests of the child' equated to safety from physical harm although there were some reflections on the detriment to the child of the removal of a parent, or removal of the child to a place of safety, and experiences of local authority care. Even so, safety from physical harm dominated and was regarded by professionals as a primary duty, particularly in the current climate and evidence of professional negligence in protecting children (mostly girls) from widespread sexual abuse.

Culture was addressed somewhat differently in each workshop. In one, participants were nuanced in their approach recognising, on the one hand, that knowledge of culture and cultural practices might be important pieces of information for professionals tasked with investigating and perhaps further intervening in families. On the other hand, concerns were also expressed that this should not lead to stereotyping or overlooking other, potentially equally important factors, such as age, for example, with respect to very young mothers. One participant also noted the difficulties families might face when having to comply with majority cultural norms and laws which contrasted with generations of experience within the family. By contrast, in the other group, participants focused more on cultural difference among recent migrants to the UK, who had to be 'educated' in the right ways of parenting and childcare, but with a clear 'bottom line' for intervention. There was an assumption that these minority cultures were both homogenised and hyper-patriarchal, within which women and children were more accepting of abuse. This required professionals to work with 'heads of households' and 'community leaders' who, in both instances were taken for granted to be male. No questions were asked of the majority culture.

There is little doubt that high profile and tragic cases in recent years, involving the deaths of children known to Children's Services, weigh heavily in the minds of professionals, especially statutory sector social workers, concerned with the protection of children. As one participant suggested, this has created an increasingly 'risk averse' environment. In this environment, 'safety first and foremost' trumps any concerns over the longer term impacts of a number of interventions on children's emotional well-being, notably removal of a parent or removal of a child from the family home. This must also be seen in the context of recent and ongoing severe austerity measures which have seen local authorities suffer significant cuts to their budgets and at the same time making it harder for lower income families to access benefits and resources.