Safeguarding and child protection in the UK

All practitioners need to understand their own role within safeguarding: what they do, as well as those parts of the process that are the direct responsibility of another professional or service. You can only make sense of your involvement by understanding the larger picture: how the broad framework for child protection developed in the UK and key issues for the system to work effectively.

The main sections of this chapter cover:
- Law and guidance for safeguarding
- Changes in the child protection system
- Process and steps of safeguarding.

Law and guidance for safeguarding

The view is now well established that parents, or any other family members, cannot simply deal with children, or adolescents, as they please. Society, backed by legislation, leaves parents considerable flexibility in how they raise their sons and daughters, but reserves the right to intervene when their safety or continued well being is under threat. Services and settings are also accountable for their practice; professionals cannot argue that their knowledge or expertise places them beyond challenge. Of course, laws do not automatically change people’s behaviour or attitudes. However, legislation makes a very public statement about what is acceptable or unacceptable within society.

Leading up to current practice

The main framework of child protection in the UK is a relatively recent development. But it would be wrong to assume that previous generations were uncaring about the ill-treatment of children. Some of the national children’s charities were set up before the twentieth century, by individuals who were deeply moved by the plight of abandoned children. Captain Thomas Coram fund-raised tirelessly to open his Foundlings Hospital in 1741 and the Coram Family organisation still operates in London today. Dr Thomas Barnardo set up his first orphanage for homeless boys in 1870 and Barnardo’s continues to be an active national organisation. The National Society for the Prevention of Cruelty to Children (NSPCC) was established in 1884 by the Reverend Benjamin Waugh and
like-minded people who were shocked by the fact that a law against cruelty to animals had been passed, with no equivalent legislation about children. Energetic lobbying by the NSPCC led to the first English Prevention of Cruelty to Children Act in 1889, which created the option of prosecution. The NSPCC set up a national network of centres and inspectors, and for many decades they were more active in child protection than local authorities.

Children with repeated, hard-to-explain injuries remained a medical puzzle until 1961, when Henry Kempe, in a presentation to the American Academy of Pediatrics, described what he called ‘the battered child syndrome’. This public discussion opened up a serious debate about the notion that adults, including parents, sometimes intentionally injured children. Tragically, it took the non-accidental death of a child to bring the reality of physical abuse effectively into the public arena, when, in 1973, seven-year-old Maria Colwell was killed by her stepfather. Maria was known to be at risk by the local authority (Brighton, England). The public inquiry in 1974 criticised the lack of communication between the various agencies involved with the family. The child protection register, first known as an ‘At Risk Register’, was established in 1975 as a national requirement for local authorities to improve contact in such situations.

Over the second half of the twentieth century a far greater awareness grew of the complexity of child abuse. Children and young people could be physically attacked but they were also put at serious risk by neglect of their basic needs, emotional maltreatment and sexual abuse within, or from outside, the family. Initially, the focus for abuse was on ill-treatment of children from their own family. But cases emerged, some dating back many years, where children had been abused by adults within the context of their professional role. Physically abusive and neglectful regimes had sometimes been justified as necessary discipline or tough training regimes. Any hopeful predictions about likely abusers were swept away as it became clear that there are no neat certainties. Abusers have been men and women, from any social class, ethnic group, cultural background and faith. The most likely abuser is an adult, but young people (under-18s) have abused peers or younger children.

If you want to find out more
Barnardos – www.barnardos.org.uk/who_we_are/history.htm
Coram Family – www.coram.org.uk/section/about/our-heritage

Laws and guidance
Within the UK, some laws passed by the Westminster Parliament apply to all four nations: England, Wales, Scotland and Northern Ireland. However, some legislation only applies to England and Wales and those two nations may differ in their application of the final details of practice. Scotland passes laws applicable
only to that nation through the Scottish Parliament, and Northern Ireland has the same power within the Northern Ireland Assembly.

The laws described in this section are primary legislation and the requirements built into the laws must be obeyed. However, legal language is not expressed in ways that make it easy for people without a legal background to understand what laws mean for daily life. Sometimes the relevant government department issues further information through books of guidance. These documents do not have the same force as primary legislation. But when they are described as ‘statutory’, it is required that local authorities, or relevant organisations, follow the details of guidance or a code – or can provide a very good reason for variation. For example, *Safeguarding Children and Safer Recruitment in Education* (2007) is statutory guidance for England (www.education.gov.uk/publications/eOrderingDownload/Final 6836-SafeGuard.Chd bkmk.pdf).

Guidance documents often describe what would be regarded as best practice wherever you work within the UK. However, you need to recall that statutory guidance from elsewhere may refer to law that does not necessarily apply to your provision. Some good practice guidance is ‘recommended’, meaning that the associated government department strongly advises that the suggestions and examples are followed. The process of developing guidance often goes through a consultation phase. The draft guidance, or a report with practical recommendations, is available on the relevant website and anyone can make comments and suggestions.

The devolution process for Wales did not extend to the right to set its own laws. However, the Welsh Assembly exerts considerable influence over how legislation is implemented. Documents such as *Children and Young People: Rights to Action* (2002) set out a clear national plan that is stronger than the equivalent government documents for England on implementing children’s rights (http://wales.gov.uk/topics/childrenyoungpeople/publications/rightstoaction/?lang=en).

### What does it mean?

**Primary legislation:** laws that have been passed for a given country. The detail of law defines what is legally required or has been made illegal. The name of a law is given with the date when it was passed by Parliament or Assembly. Sometimes parts of a law do not become fully applicable until a given later date.

**Statutory guidance:** material issued by the relevant government department to explain in non-legal language what must be done or not done.

**Good practice guidance:** material to support professionals to put law and statutory guidance into daily practice. These publications may be ‘recommended’ by the relevant government department.

**Consultation:** the process by which draft guidance is made available on a government website. Anyone can make comments or suggestions.
Procedures, guidelines and advice
Statutory guidance, backed up through the process of inspection, sometimes requires that services have a clear code of practice or policy on an important issue. It is expected that local authorities will develop their own child protection guidelines, grounded firmly in the relevant law and statutory guidance, in order to support local practice. Some procedures apply across authorities, with the aim of creating consistent application of safeguarding practice. For example, the London Safeguarding Children Board Committee has published the *London Child Protection Procedures* (fourth edition published in April 2011, see www.londonscb.gov.uk). The *All Wales Child Protection Procedures*, issued by the Social Services Improvement Agency (SSIA) applies legal requirements within the context of every Welsh authority (2008 edition) (http://www.ssiacymru.org.uk/media/pdf/0/4/Procedures.pdf).

These substantial documents not only explain the details of good practice, linked with national requirements, but also give information about relevant services and organisations for the area or country. Reliable websites, such as the LSCB and the SSIA, are also a valuable source of information and procedures for professionals facing a particular safeguarding issue.

The law and child protection
The shape of child protection across the UK was determined during the late 1980s and 1990s. The first new legislation was the Children Act 1989, which applied to England and Wales. The Cleveland Inquiry contributed serious concerns about a thorough process of assessment, avoiding sudden and unjustified removal of children from their family. Chaired by Dame Elizabeth Butler-Sloss, this report investigated claims of widespread sexual abuse during 1987 within families in Cleveland (England). However, plans for revising family law were already well advanced before the final report. A number of avoidable child deaths during the 1980s, caused by the actions or inaction of children’s own families, had raised serious concerns that the existing legislation was not working effectively. Legislation followed in the rest of the UK: the Children (Scotland) Act 1995 and the Children (Northern Ireland) Order 1996. Subsequent legislation has changed some details of how the child protection system works, but much of this legal framework still applies.

All these laws cover child welfare and family support in the broadest sense. The sections covering child protection are part of more wide-ranging legislation that also encompasses services for children in need. The Children (Scotland) Act 1995 stands out as the legislation that most took account of the United Nations Convention on the Rights of the Child 1989. Each Act or Order also covered the registration and inspection of early years services that fell outside the state educational system. Each law shared the key principles that should underpin all practice with children and young people:
The welfare of the child must be paramount in any work with a family; this is known as the paramountcy principle.

Work must be conducted in partnership. Professionals are expected to work together in a spirit of inter-agency cooperation and to work in a cooperative way with parents.

Children are not the possessions of their parents. Parents have responsibilities for their children, not absolute rights.

Children should preferably be raised within their own family, but their welfare requires limits to family privacy and decision making.

Each law assumed that childhood, and the need to protect, extended up to an individual's 18th birthday, with the exception of Scotland, which placed the boundary at 17 years of age.

Each law also established two broad areas of concern:

- Children and young people are judged to be ‘in need’ when their development and health cannot be guaranteed without extra support for children and their families. All disabled children were defined as ‘in need’, although Scotland extended the definition to include all children in a family where any member, adult or child, was disabled.
- Serious concerns about a child's health and development raise the possibility that they are at risk of suffering ‘significant harm’. A child's parents or other carers are failing to ensure that the child can thrive and be safe, compared with what could be expected for children of a similar age.

Promoting the well being of children in need and safeguarding children who are at risk of significant harm should be seen as two sides of the same coin. The judgement that children are suffering, or are at risk of significant harm, triggers compulsory intervention in family life through the child protection process.

However, a range of actions can be taken to protect children who are in need, as well as at risk of significant harm, including family support services. The legislation also established the types of abuse recognised in law: physical abuse, emotional abuse, sexual abuse and neglect. In Scotland, a fifth category, that of non-organic failure to thrive, was given separately from neglect.

New laws do not always repeal (or revoke) existing legislation – that is, remove a similar earlier law from the statute book. Legislation relevant to safeguarding, introduced since the Acts and Order described here, have not repealed the legislation of the late 1980s and mid-1990s. In fact, some details of safeguarding are still decided by the Children and Young Persons Act 1933. Other laws also affect safeguarding and family issues around that task; you will find examples throughout this book. In general, law affecting child protection is of two kinds:

- Civil law includes the public law that has determined the systems of child protection. It also includes private law that deals with family proceedings such as divorce and the ways in which separating adults can continue to be parents to their children in relation to issues such as contact.
● Criminal law relevant to child protection identifies what are offences against children and young people: crimes that inevitably bring police involvement.

UK law to safeguard children and young people includes a wide range of provisions to protect that do not require there to be a crime, nor for evidence to be presented that meets the standard of a criminal court case.

**What does it mean?**

**Civil law**: guides and determines disputes or problems between individuals that do not involve a criminal act.

**Criminal law**: determines which actions are criminal under a specific law and the likely consequences of being convicted in court for that criminal act.

**Repeal or revoke**: the legal step, built into some new laws, that specific sections now replace named sections in an existing law.

**Developments since the 1990s**

Law, guidance and the application to practice do not stand still. Since the 1990s, there have been significant reviews of how well the child protection system is working to safeguard children and young people effectively from harm.

**Review and public inquiry**

Government departments sometimes commission research reviews: overviews of safeguarding as a whole or reports on specific aspects of child protection. Public inquiries follow those cases when child protection has failed in some way. The different strands of overview sometimes merge in practice, for example the 2002 review by Nina Biehal and Jim Wade of children who go missing. An overview of this kind often makes practical recommendations, which contribute to the development of practice guidance. The Department for Children, Schools and Families issued such guidance in the 2009 *Statutory Guidance on Children who Run Away and Go Missing from Home or Care*: www.dfes.gov.uk/qualityprotects/pdfs/missing-children.pdf.

Around the UK, a local inquiry to review the case has to follow the death or very serious injury of a child if child abuse is either confirmed or suspected. A report is made to the Child Protection Committee or Safeguarding Board (currently the Health and Social Services Board in Northern Ireland) for the area. Such a report does not necessarily become public, although sometimes the decision is made that publication is in the public interest. That step is sometimes taken when the death of a child was avoidable and professional practice had been inadequate to protect.
Pause for reflection


Like Victoria Climbié (page 13), Peter was a child known to social care services; his name was on the child protection register and a number of agencies were involved with the family. Yet his mother’s vague explanations were accepted for a litany of injuries, key medical professionals were absent from important case meetings and no proper investigation was made of the adults living in a house where Peter and other children had already been judged to be at risk.

Consider and discuss with colleagues or fellow students how these significant issues, and others, emerge from this report.

The Department of Health (for England) is obligated to commission regular overviews of serious case reviews, following avoidable deaths or serious injuries to children. These overviews draw out the consistent themes from many case reviews, while keeping the details confidential, as in, for example, the 2002 report by Ruth Sinclair and Roger Bullock.

Significant public inquiries are organised when the events of a particular case raise serious questions about the adequacy of the existing system to protect. Such reports make recommendations, often leading to a change in guidance, and sometimes to new legislation. There have also been public inquiries following investigations into child abuse when professional opinion has been sharply divided; for instance, Lord Clyde’s judicial inquiry following the claims about ritual sexual abuse in the Orkneys (1990). Public inquiries also usually follow the discovery of significant professional malpractice in provision for children or young people, for example, the abusive ‘Pindown’ system used in Staffordshire Children’s Homes (1990).

The long-term abuse in residential children’s homes in Clwyd, North Wales, exposed finally in the mid-1990s, led to the report People Like Us, by Sir William Utting in 1997. The government’s response was to introduce the Quality Protects Programme for England – Quality First in Wales – to improve provision for looked-after children and young people. A review in 2004 by Marian Stuart and Catherine Baines identified that changes made since the Utting report had brought improvements in some aspects of practice. However, improvements were slow in some areas, such as children and young people in custody or in psychiatric hospitals.

If you want to find out more

SAFEGUARDING AND CHILD PROTECTION IN THE UK


**Focus on professional practice**

A major consequence of reviews throughout the 1990s was to show that children’s welfare may not only be endangered by their families, but also that professionals may have the potential to harm children through their actions or inaction. The concept of ‘professional dangerousness’ came into use to describe behaviour from members of relevant professions that failed to protect children effectively. This concept remains highly relevant in the twenty-first century, along with the commitment to reflective practice which it entails.

**What does it mean?**

**Professional (or organisational) dangerousness**: when inappropriate values, priorities or methods lead professionals to act in ways that fail to reduce the risk to children or young people.

Significant practice issues could increase the risk for children, even though professionals were involved with their family:

- Unsafe professionals had inadequate supervision and sometimes impossible case loads.
- An additional issue has arisen with pressure to get considerable amounts of data entered on computer files. The risk of what has been called technology-driven practice is that hard-pressed professionals may slip into placing a higher priority on inputting data than on spending time with a child whose welfare is in doubt.
- Whole teams were sometimes perplexed about how to balance anti-discriminatory practice with child protection. Anxiety about avoiding what could be interpreted as racist decisions remains a live issue that complicates safe decision making in some cases.
- A proper focus on children had sometimes been lost in favour of addressing the problems of adults and accepting their perspective on family life.
- Some professionals held on to an unrealistic optimism about the family’s ability to cope, even in the face of poor outcomes for the child.
- Some professionals had avoided contact with the family because of unacknowledged fears for their own personal safety. This situation, combined with poor support within the team, meant that nobody confronted how a child could possibly be safe in a household that professionals were afraid to visit.
A key theme in professional dangerousness for work with families is that the child has been lost as the priority in child protection. Even where parents are doing their best, given serious stress or very limited understanding of a child's needs, the final judgement has to be the well being of the child. No child can be left at risk of abuse or neglect on the grounds that, although their care is seriously inadequate, the parents could not be expected to manage any better. All involved professionals must place the child's safety and well being at the very centre of attention. Social workers, and other professionals directly involved with families, face a challenging task. They have to make genuine efforts to work with parents, who may well be supported to keep their child safe. Yet they must also be alert to parents who are only cooperative on the surface – masking an inability, or refusal, to change behaviour or a home situation which endangers a child.

During the 1990s it became clear that the full possibilities of family support services were not always used. Each Children Act and Order was set up to enable support for children ‘in need’ as well as action to protect children at risk of significant harm. Reviews highlighted that the key point of the process was not exclusively whether to place a child's name on the register and this action did not in itself protect children without effective follow-up. Family support services could be crucial to ensure that a child who was currently ‘in need’ did not slide towards ‘at risk’ and a crisis situation. Reports emphasised the obligation to involve parents as much as possible, but that professionals must not overlook listening to children, taking their views properly into account.

**Procedures have to be implemented**

Carefully drafted procedures, like any safeguarding policy, do not in themselves protect children. Two linked reports from Wales highlighted how abusive treatment was allowed to continue because the adults responsible for safeguarding made other considerations a higher priority than the welfare of children and young adolescents.

Sir Ronald Waterhouse reported in *Lost in Care* (2000), the North Wales Child Abuse Inquiry on allegations of abuse of looked-after children and young people in the Gwynedd and Clwyd areas dating back to 1974. The Waterhouse inquiry documented allegations made by some children about abusive treatment while they stayed at Gwynfa, an NHS facility in Colwyn Bay for children and adolescents with mental health problems. Sir Alex Carlile led the inquiry into these allegations. His 2003 report highlighted the risks that arose from secrecy and a feeling among staff that it was unacceptable to express any concerns about practice within their team. The Gwynfa facility had clear guidance on child protection but failed to implement procedures, using excuses such as staff shortages.

**If you want to find out more**

Focus on the child in ‘child protection’

The subtitle of the Carlile Report was ‘Too serious a thing’. The full quotation from Charles Lamb (a nineteenth-century writer) is given on the front page of the report: ‘A child’s nature is too serious a thing to admit of its being regarded as a mere appendage of another being.’ The reports from Wales highlight the great risk to children and young adolescents when protection of them becomes less important to adults than their own concerns and priorities. Adults can be culpable of neglectful inaction, even when they are not the active abusers.

Good practice in protection also has to respect the welfare and development of children as individuals in their own right. A criticism made in the public inquiry on the Cleveland sex abuse cases in the late 1980s was that the children themselves ran the risk of being lost in the flurry of diagnosis and professional counter-claim. A telling phrase from that report is still quoted: ‘The child is a person, not an object of concern.’ However, problems continued through the 1990s, as shown in later reports on professional misconduct in dealing with claims of widespread sexual abuse within a community, for example in the Orkneys. There is a significant risk to children and young people when professionals are so convinced that abuse has occurred that they refuse to believe the children's protestations; indeed, the denial was sometimes taken as a sure sign that something had happened (the child was ‘in denial’). Such public inquiries also highlighted that professionals must follow codes of conduct for how a child is interviewed and a high standard of documentation of that process.

Agencies must work together

An additional problem arose when a service simply did not view children and adolescents as part of their brief. There are now stronger messages for professionals within adult disability, mental health or addiction services to look beyond their own adult client or patient. Such services should at least check whether an adult who faces a daily struggle to take care of themselves is also responsible, in theory, for a child or young person. The review by Marian Brandon et al. (2009) confirmed the risks to children and adolescents when professionals stuck rigidly to their own brief, either in terms of a narrow focus on a child or being oblivious to the possible risks to children within the same home as an adult with serious problems. The message is that this insular ‘silo practice’ has to be challenged by professional understanding that safeguarding children is everybody’s business.

If all the different sources of knowledge are brought together, then the seriousness of the situation for a child or young person can be far more obvious.

- The most useful image is that of a jigsaw, for which different professionals or services each have only a few of the total number of pieces.
- Children are not well protected when roles and responsibilities between agencies are not clear.
- It is too easy for everyone to assume that somebody else ‘knows about …’ or ‘is doing something about …’. Yet the real situation is that nobody has taken responsibility for this matter.
- Action to protect is undermined when there is a different professional approach to confidentiality and information sharing, perhaps worsened by feelings about professional territory.
- Those practitioners in different professions who are vital to the full safeguarding picture need to address potential communication problems that may result from placing a different meaning on terms such as ‘vulnerable’, for example.

More than one inquiry has stressed the need to use observations and assessments made by people who see the child(ren) regularly. If all the different reports and knowledge of children are brought together, then the seriousness of the situation for the children can be far more obvious than when considering one perspective. Some reviews stressed the great importance of consulting individuals and group settings where children and young people were seen on a regular basis, sometimes daily. To return to the image of the jigsaw, practitioners in nursery, school and out-of-school facilities, or the childminding service, can hold significant pieces.

**Learning from what has gone wrong**
The final reports of public inquiries and reports of local reviews that have been made public usually make recommendations. However, the broad impact of high-profile cases is that everyone becomes unsettled, not only those in that geographical or professional area. The experience of tragedy or the discovery of professional misconduct shakes general morale and confidence. A well-run public inquiry can identify key issues for best practice that need to be addressed. However, systems and policies are only as effective as the people who put them into practice day by day, week by week. Changes in the law or guidance do not in themselves transform practice to protect children. Adults have to change, or be enabled to change, their professional behaviour, priorities and outlook.

The high level of media involvement in tragedies involving children is now a complicating factor. Social workers and other professionals can find themselves criticised, even vilified, in public, well before it is clear what went wrong. One of the alleged consequences of everything that happened around the death of young Peter Connelly has been an increase, maybe short term, in over-cautious moves to take vulnerable children into care. Social workers can then find themselves heavily criticised for overreacting and failing to give families opportunity and support to change for the better.

Nick Alford and Roger Bullock were commissioned to undertake a research overview of child death and significant case reviews as part of the Child Protection
Reform Programme (CPRP) in Scotland. Their 2005 report highlights several key points:
● Child deaths resulting from abuse or neglect are relatively rare. It can be problematic if significant changes are made to the safeguarding system specifically to avoid the repetition of an unusual event. The point is not, of course, to ignore inexcusable failures to apply existing guidance to protect.
● The majority of children who are in need of protection experience levels of abuse that, although unacceptable, are not life threatening. Their safety can be ensured, with effective child protection practice, while they continue to live with their family and promptly receive appropriate services.
● Patterns of cause and effect can appear more obvious with hindsight. Indeed, some children’s injuries, trauma or death have been the result of serious failures of people and services. However, it is much harder in most cases to predict the likelihood of a very serious or tragic outcome while the situation is ongoing.
● The important focus for safeguarding is that a great deal is now known about factors that increase the level of risk to a child or young person. The aim of detailed assessment procedures is to assess that risk and not try to predict the future in detail. Effective safeguarding is a matter of ‘most probably could’, ‘easily might’ and rarely of ‘definitely will’.

If you want to find out more

Take another perspective
You need to remind yourself that serious mistakes and tragedies are far more likely to become public knowledge than when children have been protected and are therefore safe. Headlines are not created from ‘Social workers intervene and life is much better for young Matthew’. Partly, such events are not deemed to be newsworthy, but also the details remain confidential to the family and involved professionals.
There have been serious failures of safeguarding that have led to deep distress, injury and even death for some children. This section has focused on overviews which highlight good practice, as well as that which is less adequate, and public inquiries, which arise because safeguarding has not worked to protect children or young people. The clear message of more recent inquiries is that problems are not a matter of deep history. Systems still fail some children and young people through the actions or inactions of key people or their inadequate knowledge.